2012

MO HealthNet Managed Care Program

External Quality Review

Report of Findings

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1.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet Managed Care Health Plans (MCHPs) and their contractors to participants of MO HealthNet Managed Care services. The CMS (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid Managed Care programs. These rules require a desk review as well as an on-site review of each MCHP.

The State of Missouri contracts with the following MCHPs represented in this report:

- HealthCare USA (HCUSA)
- Home State Health Plan (Home State)
- Missouri Care (MO Care)

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

1) Validating Performance Improvement Projects[1]
Each MCHP conducted performance improvement projects (PIPs) during the 12 months preceding the audit; six of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency [(SMA; Missouri Department of Social Services (DSS), MO HealthNet Division (MHD]).

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September, 2012. Washington, D.C.: Author.

2) Validating Performance Measures[2]

The three performance measures validated were HEDIS 2012 measures of Annual Dental Visit (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow Up After Hospitalization for Mental Illness (FUH).

NOTE: Because HEDIS 2012 data is actually calendar year 2011 data, the Performance Measures validation included in this report will include data from the six MCHPs that were under contract with MO HealthNet during calendar year 2011. The inclusion of all six MCHPs is necessary to present a statewide picture of HEDIS 2012. Those six MCHPs include:

- Blue Advantage Plus of Kansas City (BA+)
- Children's Mercy Family Health Partners (CMFHP)
- Harmony Health Plan of Missouri (Harmony)
- HealthCare USA (HCUSA)
- Missouri Care (MO Care)
- Molina Healthcare (Molina)

3) MO HealthNet MCHP Compliance with Managed Care Regulations.[3]

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis): and

4) Special Project – Case Management Record Review

The EQRO reviewed a random selection of Case Management files for each MCHP. These files were evaluated based on the requirements set forth in the MCHPs' contract with the SMA to deliver MO HealthNet Managed Care services.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, D.C.: Author.
[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

1.2 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs (one clinical and one non-clinical) for each MCHP that were underway during 2012. A total of 6 PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, SMA, and the EQRO. The final selection of the PIPs for the 2012 validation process was made by the SMA in February 2013. The SMA directed the EQRO to validate the statewide PIP, Improving Oral Health. Below are the PIPs identified for validation at each MCHP:

HealthCare USA	Readmission Performance Improvement Project Improving Oral Health
Home State Health Plan	Notification of Pregnancy Form Receipt Improvement Improving Oral Health
Missouri Care	Comprehensive Diabetes Care Improving Oral Health

The focus of the PIPs is to study the effectiveness of clinical and/or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the Managed Care contract, each MCHP is required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each MCHP by the EQRO during the site visits for improving study methods, data collection, and analysis.

The EQR is tasked with reporting how Medicaid Managed Care participants access care, the quality of care participants receive and the timeliness of this care. CMS requests that the EQRO report on those three areas of care in each area of validation.

Access to Care

Access to care was an important theme addressed throughout the PIP submissions. A major goal of the statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual oral health PIP projects developed by each MCHP. Access to care was also an important focus in the clinical PIPs. Each of the MCHPs focused on assisting and educating members in developing PCP and specialist relationships. This is in an effort to obtain access to healthcare. These PIPs had a significant focus on providing access to the correct medical provider through a variety of interventions. All the projects reviewed used the format of the PIP to improve access to care for members. The clinical topics focused on early access to prenatal care; improved outreach and in-home services for members leaving the hospital; and improved prevention and primary care for members with diabetes. The on-site discussions with MCHP staff indicated they realize that improving access to care is an ongoing aspect of all projects that are developed.

Quality of Care

Topic identification was an area that provided evidence of the attention paid to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP or in the direct provision of services delivered. The corresponding interventions that addressed barriers to quality care and health outcomes were clearly evident in the narratives submitted, as well as in the discussions with MCHPs during the on-site review. These interventions addressed key aspects of enrollee care and services, such as: use of additional case management and in-home service; monitoring provider access and quality service provision; and preventive care. These efforts exemplified an attention to quality healthcare services.

Timeliness of Care

Timeliness of care was also a major focus of the PIPs reviewed. These projects addressed early involvement in prenatal care, immediate services upon release from hospitalization, and immediate management of members' health when diagnosed with diabetes. These projects addressed the need for timely and appropriate care for members to ensure that services are provided in the best environment in a timely manner. The need for timely access to preventive and primary health care services was recognized as an essential component of these projects. The MCHPs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness, as they addressed internal processes and direct service improvement.

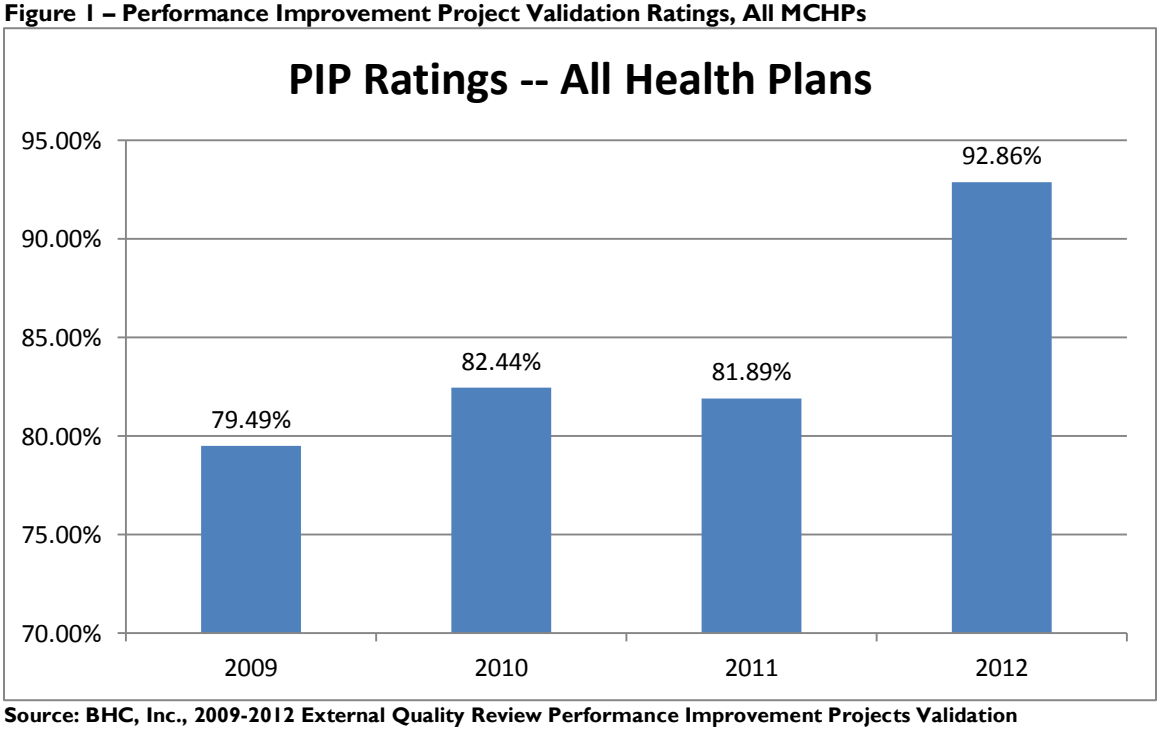
The PIPs related to improving Annual Dental Visits included a focus on obtaining timely screenings and recognized that this is an essential component of effective preventive care.

CONCLUSIONS

The MCHPs have made significant improvements in utilizing the PIP process since the EQRO measurement process began. In the past four years the MCHPs have had a large percentage of the steps required to preparing and presenting a PIP considered as "Met." Each step is evaluated based upon all information gathered in the review process. These steps are graded with the goal of reaching the target of complete and accurate information, which is coded "Met."

Figure 1 indicates the improvements the MCHPs have made in providing valid and reliable data for evaluation. In 2009 the MCHPs only achieved an overall rating of 79.49%. The MCHP's continue to improve in presenting valid and reliable date and exhibit a commitment to the PIP process as a method of improving quality. The 2012 rating of 92.86%, including a new MCHP, indicates an emphasis on quality initiatives.

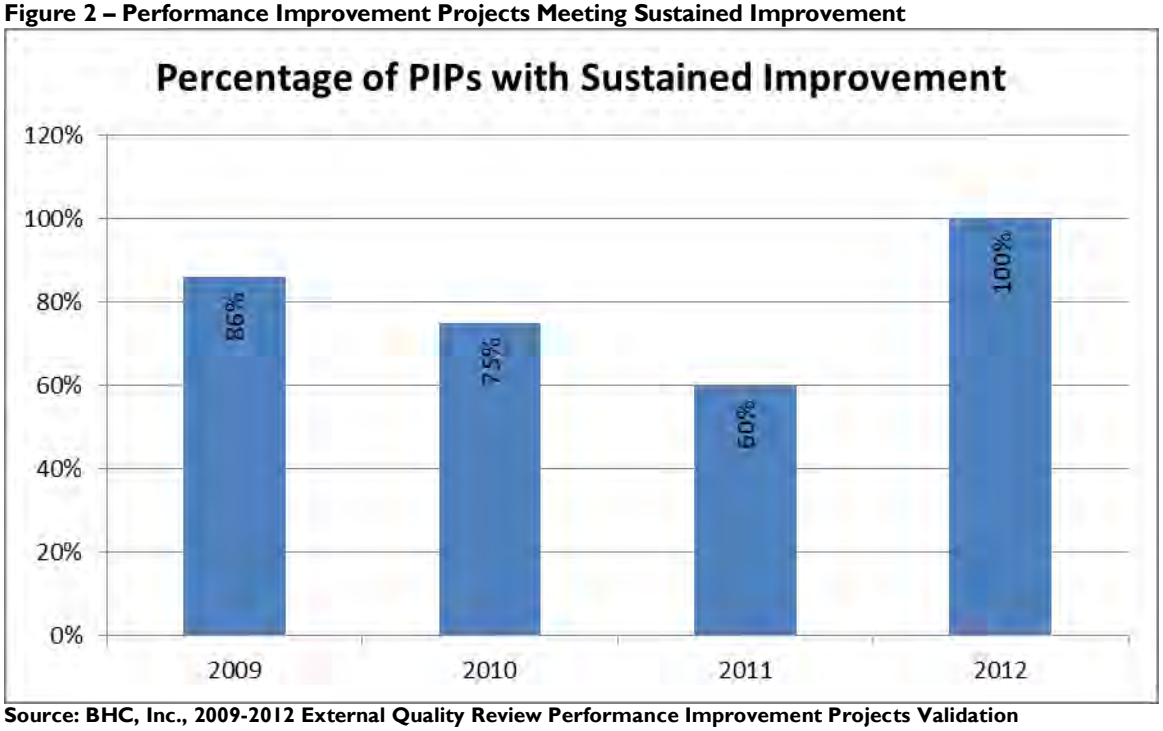
Figure 1 – Performance Improvement Project Validation Ratings, All MCHPs



Source: BHC, Inc., 2009-2012 External Quality Review Performance Improvement Projects Validation

Figure 2, an essential element of validating these projects is represented: analyzing the projects' ability to create sustained improvement. This analysis is only preformed on PIPs that are mature in their process. In 2009, this measure was rated at 85.71%. In 2010, only four PIPs were considered mature enough to evaluate their ability to produce sustained improvement. Of those four PIPs three were considered likely to sustain improvement, thereby the PIPs are only rated as 75% compliant for the 2010 review. This **declined** for the 2011 review to 60%, as five PIPs where considered mature enough to evaluate for sustained improvement and three of those five received ratings that showed sustained improvement. This decline is attributable to the lack of participation of Molina Healthcare of Missouri in the 2011 on-site reviews. For 2012, three PIPs were considered mature enough to evaluate the possibility of sustained improvement and all three received ratings that showed sustained improvement (100% compliant).

Figure 2 – Performance Improvement Projects Meeting Sustained Improvement



Source: BHC, Inc., 2009-2012 External Quality Review Performance Improvement Projects Validation

1.3 Validation of Performance Measures

The Validation of Performance Measures Reported by the MCO Protocol requires the validation or calculation of three performance measures at each MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each MCHP on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS). For the HEDIS 2012 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow-Up After Hospitalization for Mental Illness (FUH). Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, MCHP extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to DHSS was based on MCHP performance during 2011.

> **NOTE:** Because HEDIS 2012 data is based on calendar year 2011 data, the Performance Measures validation included in this report will include data from the six MCHPs that were under contract with MO HealthNet during calendar year 2011. The inclusion of all six MCHPs is necessary to present a statewide picture of HEDIS 2012. Those six MCHPs include:
>
> - Blue Advantage Plus of Kansas City (BA+)
> - Children's Mercy Family Health Partners (CMFHP)
> - Harmony Health Plan of Missouri (Harmony)
> - HealthCare USA (HCUSA)
> - Missouri Care (MO Care)
> - Molina Healthcare (Molina)

Only two of the six MCHPs operational during the 2011 Calendar Year were still under contract with the State of Missouri at the time this review commenced. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data, however, for comparison and state-wide rates, the rates reported by all six MCHPs are included in the analysis.

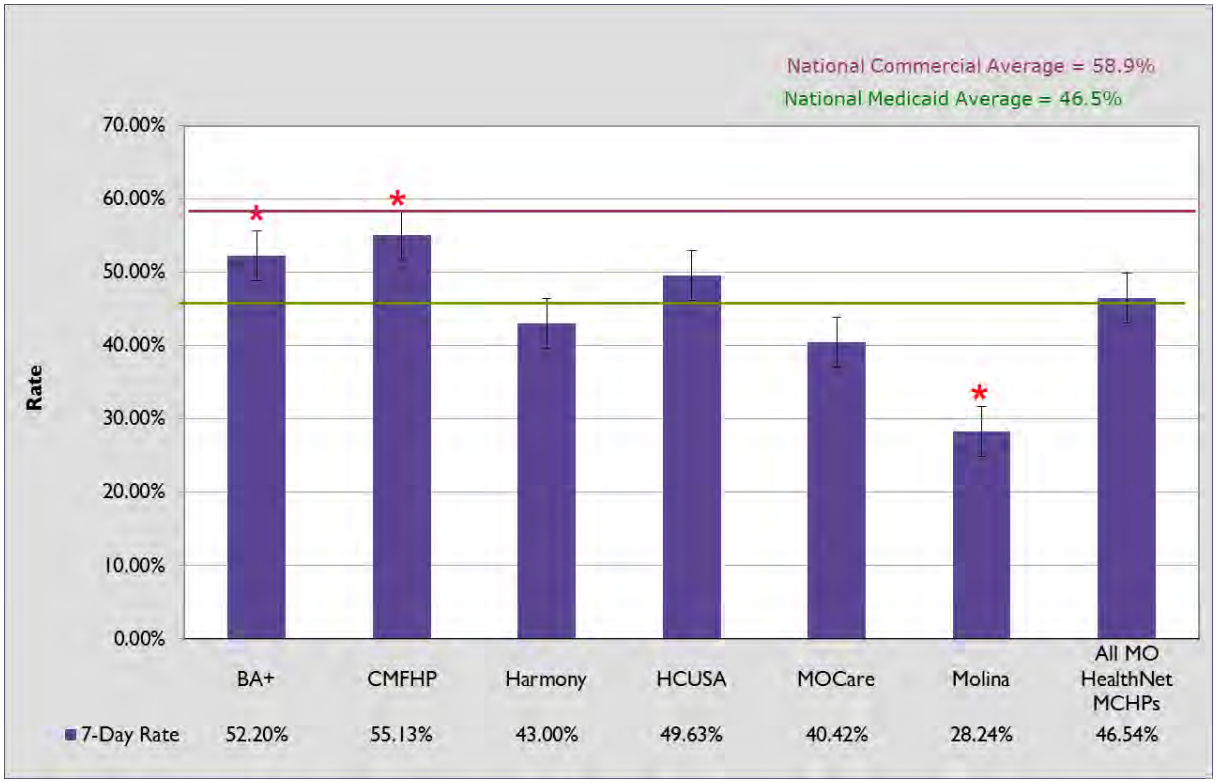
QUALITY OF CARE

The HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by MCHP members. Of the two MCHPs that were fully validated by the EQRO, one was Fully Compliant with the specifications for calculation of this measure and the other MCHP was substantially complaint with the specifications for calculation of this measure.

Although the rates could not be validated for all six MCHPs that delivered services to Managed Care members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

For the 7-day follow up rate, three MCHPs (BA+, CMFHP and HCUSA) reported rates (52.20%, 55.13% and 49.63%, respectively) that were higher than the National Medicaid Average (46.5%) for this measure. The statewide rate for all MCHPs (46.54%) was also higher than the National Medicaid Average.

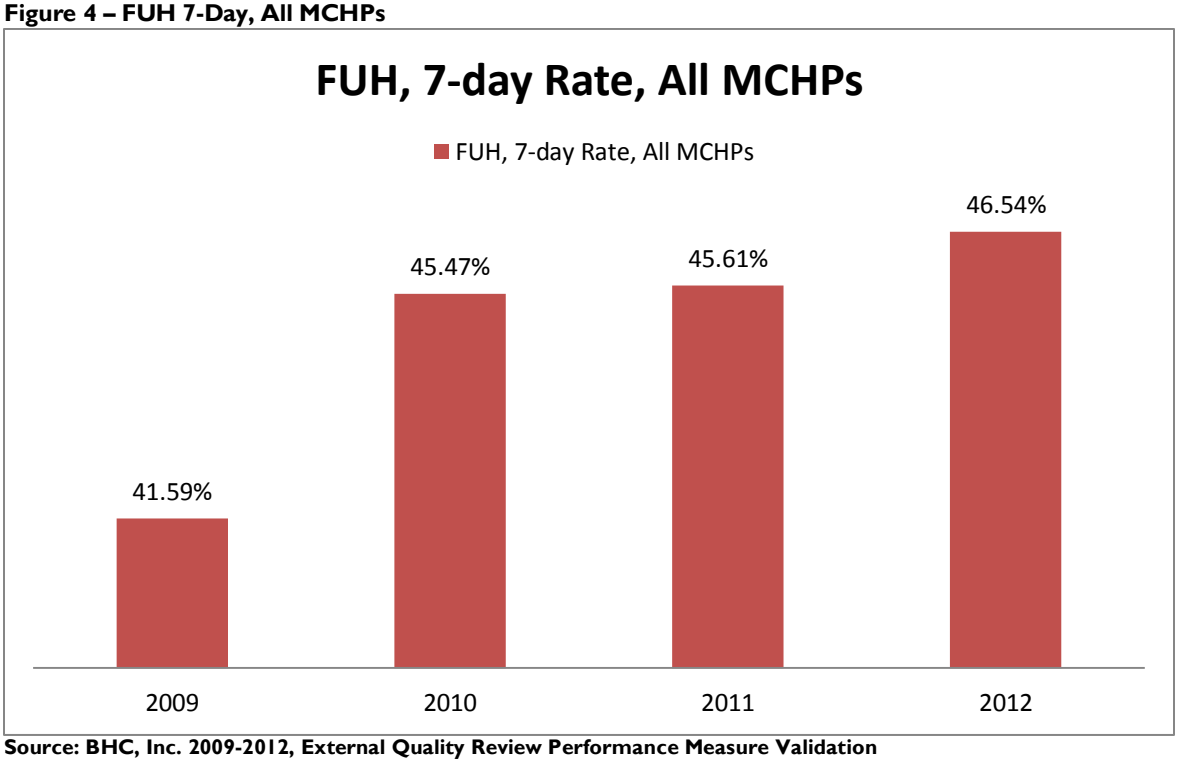
Figure 3 - Managed Care Program HEDIS 2012 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.
Sources: MCHP HEDIS 2012 DST; National Committee for Quality Assurance (NCQA).

This measure was previously audited by the EQRO in audit years 2009, 2010 and 2011. The 7-Day reported rate for all MCHPs in 2012 (46.54%) continues a steadily increasing trend, as access to follow-up services after hospitalizaton for mental illness continues to improve for MOHealthNet Managed Care recipients in Missouri.

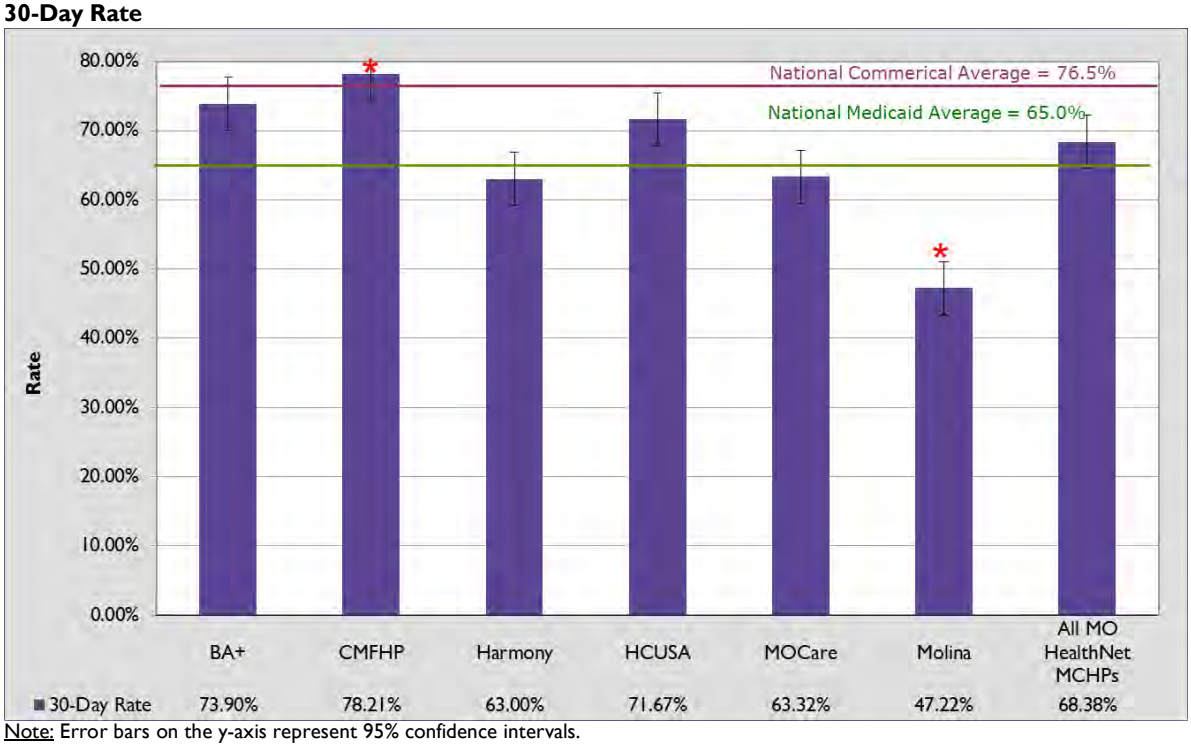
Figure 4 – FUH 7-Day, All MCHPs



Source: BHC, Inc. 2009-2012, External Quality Review Performance Measure Validation

For the 30-day follow up rate, three MCHPs (BA+, CMFHP, and HCUSA) all reported rates (73.90%, 78.21% and 71.67% respectively) that were above the National Medicaid Average (65.0%) for this measure. The overall MO MCHP rate (68.38%) was also higher than the National Medicaid Average.

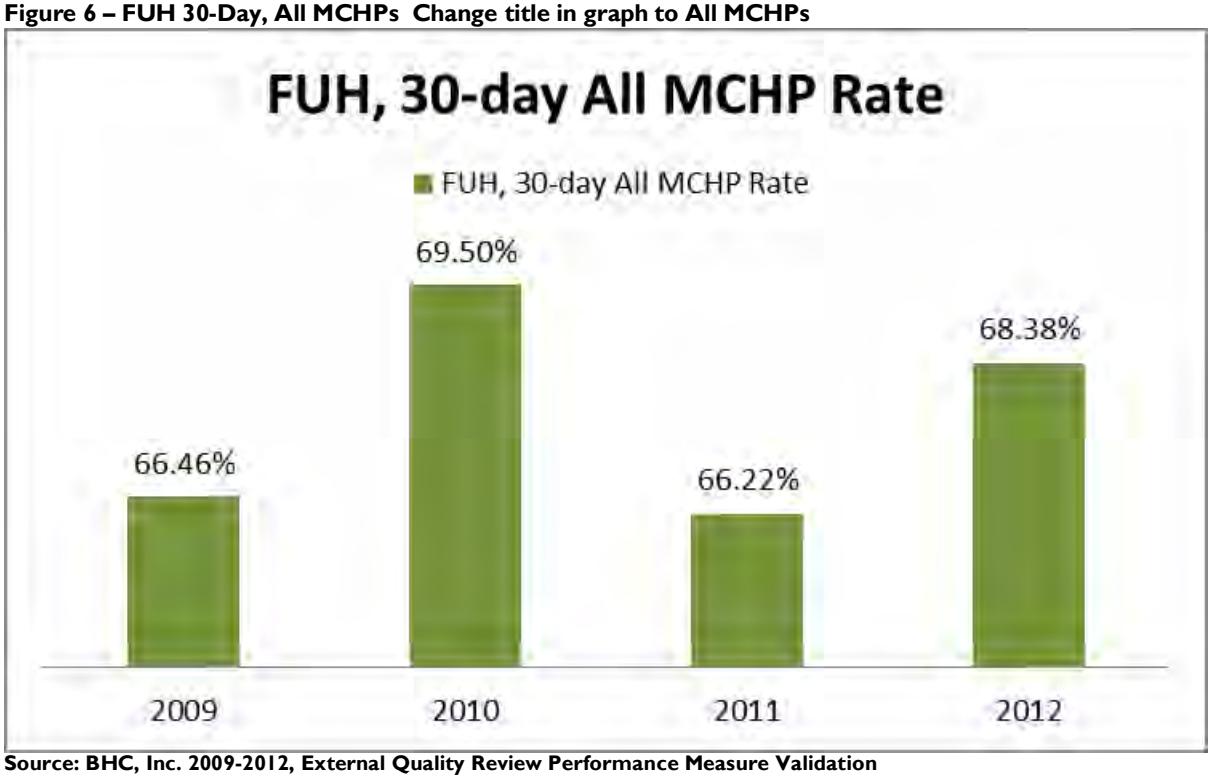
Figure 5 - Managed Care Program HEDIS 2012 Follow-Up After Hospitalization (FUH) for Mental Illness, 30-Day Rate



Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MCHP HEDIS 2012 DST; National Committee for Quality Assurance (NCQA)

This measure was previously audited by the EQRO in audit years 2009, 2010, and 2011. The 30-Day reported rate for all MCHPs in 2012 (68.38%) was an increase from the 2011 rate (66.22%), but was a decrease from the rate reported in 2010 (69.50%). However, the overall rate still remains higher than the rate reported in 2009 (66.46%).

Figure 6 – FUH 30-Day, All MCHPs Change title in graph to All MCHPs



Source: BHC, Inc. 2009-2012, External Quality Review Performance Measure Validation

From examination of these rates, it can be concluded that MCHP members are receiving a quality of care comparable to or higher than other Medicaid participants across the country within the 30-day timeframe for the area of Follow-Up After Hospitalization for Mental Illness. However, the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. Based on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has increased over time in Missouri for both the 7-day and 30-day timeframes.

Access to Care

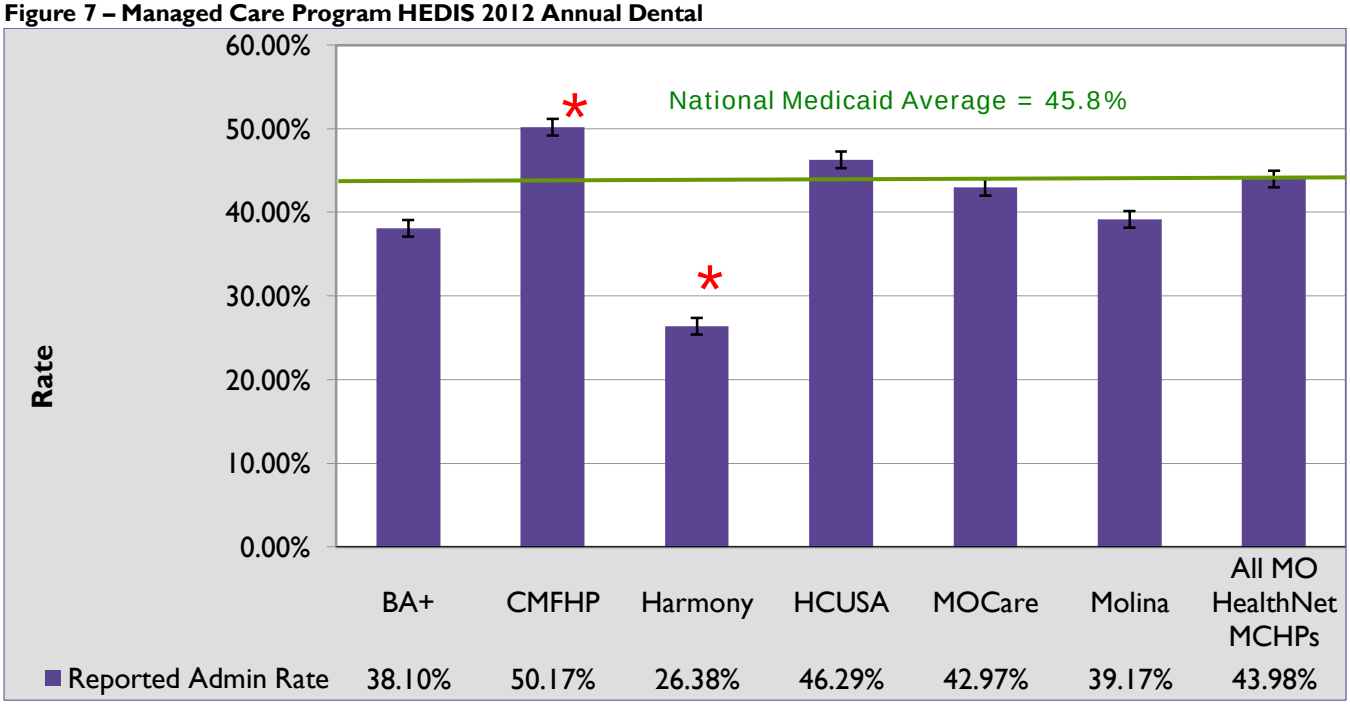
The HEDIS 2012 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure.

Although the rates could not be validated for all six MCHPs that delivered services to Managed Care members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

The Annual Dental Visits measure was audited in the 2009, 2010, 2011, and 2012 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved steadily. In 2012, two MCHPs reported rates higher than the National Medicaid Average of 45.8%, these MCHPs are CMFHP (50.17%) and HCUSA (46.29%).

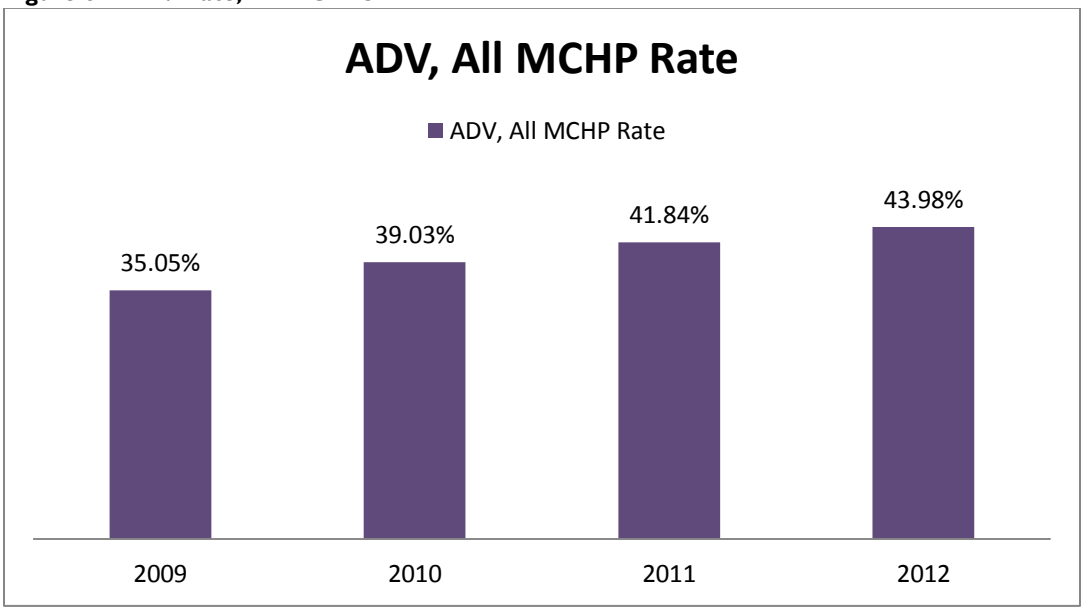
Figure 7 – Managed Care Program HEDIS 2012 Annual Dental



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2012 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

This trend shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2012 measurement year.

Figure 8 – ADV Rate, All MCHPs



Source: BHC, Inc. 2009-2012, External Quality Review Performance Measure Validation

TIMELINESS OF CARE

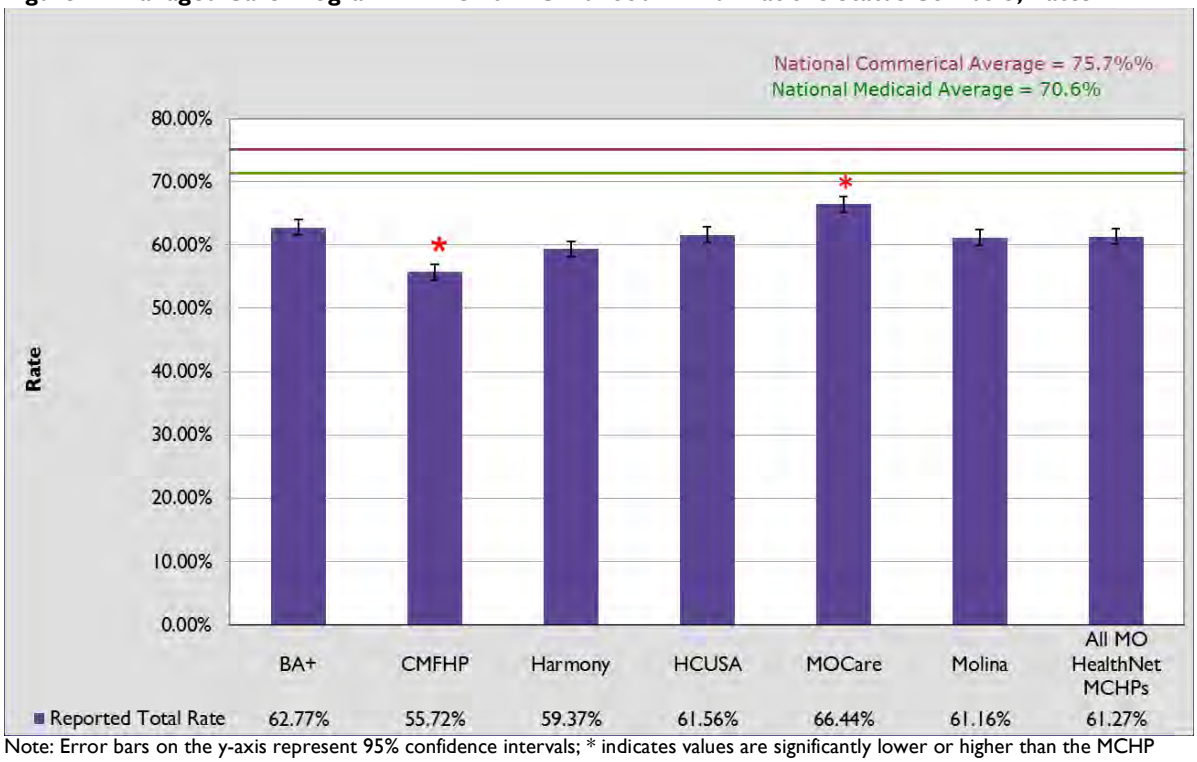
The HEDIS 2012 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure. Although the rates could not be validated for all six MCHPs that delivered services to Managed Care members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

Combination 3 for this measure was audited in 2011, however, it was not previously audited, therefore not enough data exists for trend analysis. The statewide rate reported for Childhood Immunizations Status, Combination 3 measure in 2012 (61.27%) was **higher** than the rate reported

in 2011 (57.47%). None of the MCHPs reported a rate in 2012 higher than the National Medicaid Average of 70.6% or the National Commercial Average of 75.7%.

Figure 9 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Sources: MCHP HEDIS 2012 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

This illustrates a timeliness of care for immunizations delivered to Managed Care children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

1.4 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor MCHP Compliance with Managed Care Regulations is to provide an independent review of MCHP activities and assess the outcomes of timeliness and access to the services provided. The protocol requires the utilization of two main sources of information to determine compliance with federal regulations. These sources of information are document review and interviews with MCHP personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MCHP.

The policy and practice in the operation of each MCHP was evaluated against the seventy (70) regulations related to operating a Medicaid Managed Care Program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MCHP's policy to determine compliance with the requirements of the Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

This year's review (calendar year 2012) is a full compliance review, follow-up reviews will be conducted for 2013 and 2014. The EQRO reviewed the compliance of the three MCHPs that were providing services at the end of calendar year 2012. These MCHPs included:

- HealthCare USA
- Home State Health Plan
- Missouri Care

The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management processes. The review included case record reviews and interviews with Case Management and Administrative staff. The results of the Case Management review will be reported in detail in another section of this report as a "Special Project". The interview tools used were based on information obtained from each MCHPs' 2012 Annual Report to the SMA and the SMA's Quality Strategy.

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP's contract compliance. This information

was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered was assessed, re-reviewed, and translated into recommended compliance ratings for each regulatory provision.

Quality of Care

For all the MCHPs, all of the 13 regulations for Enrollee Rights and Protections were 100% "Met." These regulations include:

- Communicating Managed Care Members' rights to respect, privacy, and treatment options were primary and compliant.
- Communicating, orally and in writing, in the member's native language or with the provision of interpretive services is an area of strength for all MCHPs.
- The MCHPs recognized these requirements are essential to create an atmosphere of delivering quality healthcare to members.
- The MCHPs maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare.
- The MCHPs responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.
- The MCHPs demonstrated an awareness of Enrollee Rights and Protections by having standards and practices in place that were compliant and evident in discussions with staff who interact directly with members. The attention to ensuring quality care was apparent throughout each of the MCHPs.

For all the MCHPs, all of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the second year in a row that these two MCHPs (HCUSA and MO Care) maintained a 100% rating in this set of regulations. These MCHPs articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their Managed Care members. These regulations include:

- Provider selection and network maintenance, subcontract relationships, and delegation.

- The MCHPs had active mechanisms for oversight of all subcontractors.
- The MCHPs improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their Managed Care members.

Access to Care

The two MCHPs (HCUSA and MO Care) that have been previously audited by the EQRO **improved** in their compliance with the 17 federal regulations concerning Access Standards during this year's review. These two MCHPs were 88.24% compliant. The remaining MCHP (Home State) was found to be 64.71% compliant with these standards.

Although the EQRO observed that most of the MCHPs had active case management services in place, the records requested did not always contain information to substantiate these observations. Each MCHP described measures they used to identify and provide services to Managed Care members who have special healthcare needs. All of the MCHPs could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The MCHPs were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members. One area of concern is care coordination. Although the MCHPs had the required policy in place, none of them were able to demonstrate through chart review that they had fully compliant care coordination processes in place.

Timeliness of Care

This is a much improved area of compliance for all the MCHPs. Ten of the eleven regulations for Measurement and Improvement were 100% "Met." However, only one of the three MCHPs met all of the regulatory requirements. All of the MCHPs adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. These MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.

The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations

Departments of the MCHPs. This was not always evident in the documentation reviewed. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of members. The MCHPs all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

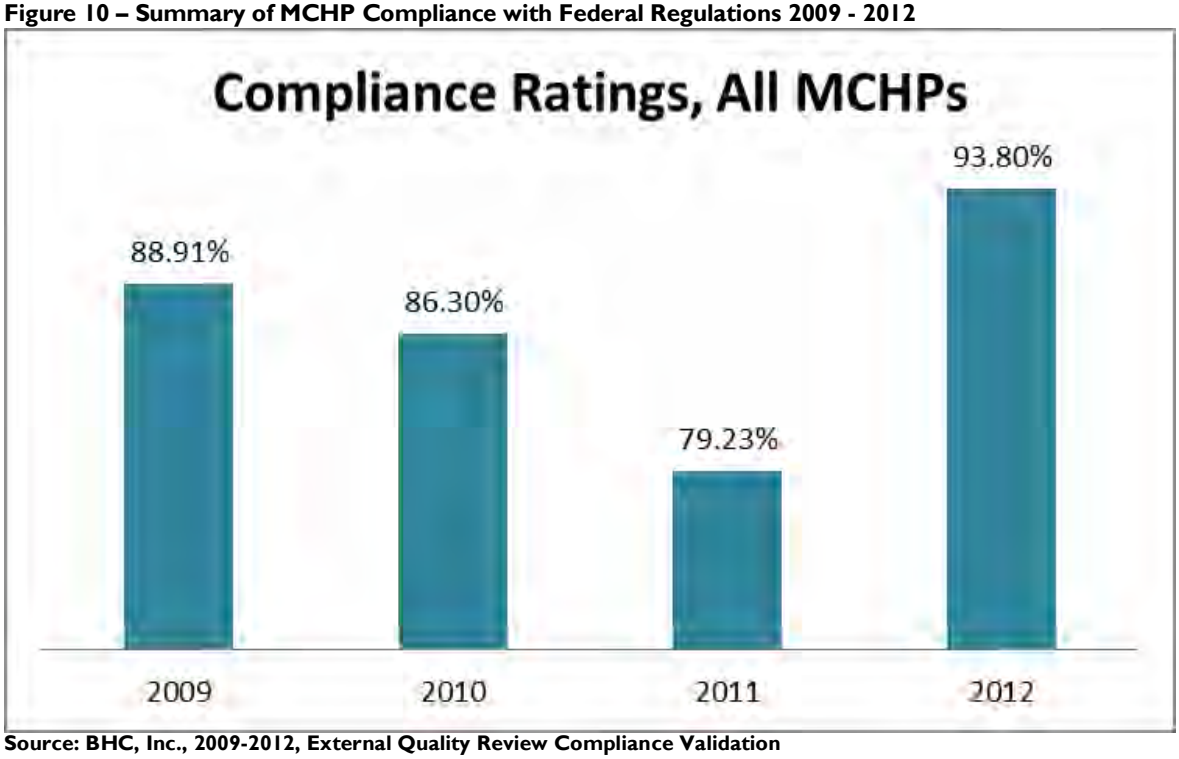
All of the regulations for Grievance Systems were 100% "Met" for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs.

MCHPs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to members. The MCHPs observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

CONCLUSIONS

The MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the MCHPs did not have complete and approved written policies and procedures and MCHP processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements, the MCHPs made concerted efforts to complete policy and procedural requirements. In 2007-2012, the review examined not only the written policy, but also conducted interviews to identify if the activities of front line and administrative staff were in compliance. The MCHPs have used previous EQRs to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

Figure 10 – Summary of MCHP Compliance with Federal Regulations 2009 - 2012



Source: BHC, Inc., 2009-2012, External Quality Review Compliance Validation

Across all three MCHPs there is a commitment to improving and maintaining compliance with federal regulations. There are only a few regulations rated as "Not Met". All other individual regulations were rated as "Met" or "Partially Met". All MCHPs were 100% compliant with three of the compliance areas validated during this review year.

For the third year in a row, none of the MCHPs were 100% compliant with all requirements. This is attributable to the in-depth review of the MCHPs' Performance Improvement Projects and the Case Management Special Project review. All MCHPs were unable to demonstrate case management information that fully exhibited compliance with the aspects care coordination. However, the overall compliance ratings have improved significantly from the prior year's review.

1.5 MO HealthNet MCHP Special Project – Case Management Performance Review

INTRODUCTION

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the results of the 2010 and 2011 reviews of the MCHPs' compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services.

The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to:
    a. Pregnant members;
    b. Members with special health care needs; and
    c. Children with elevated blood lead levels;
- Assessing the MCHP's response to referrals that result from members who frequent the Emergency Room as a source of primary care;
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases they report as open in their system.

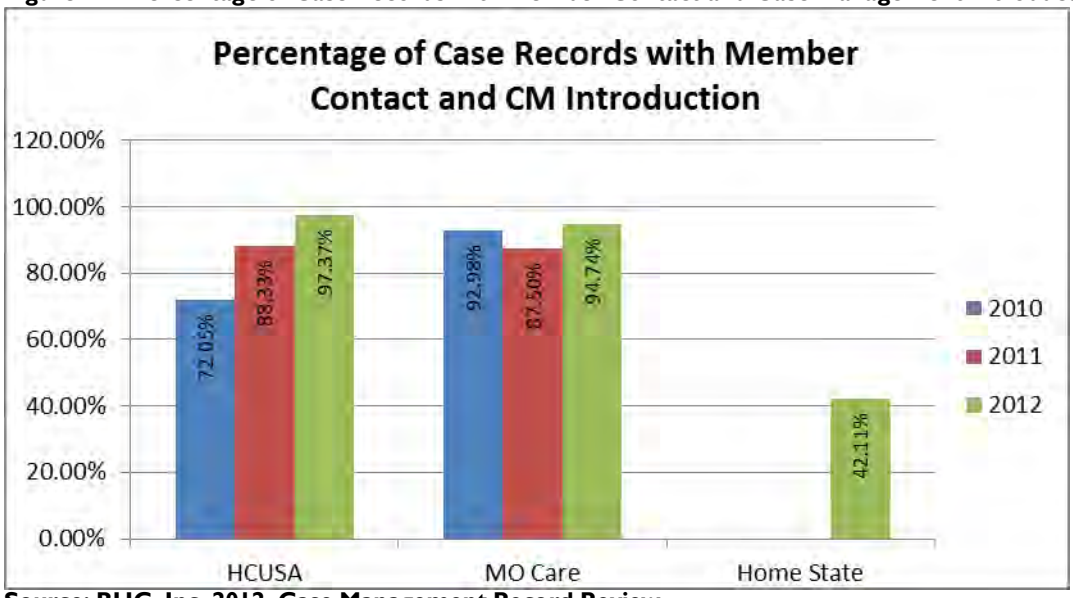
OBSERVATIONS AND CONCLUSIONS

INTRODUCTION TO CASE MANAGEMENT

There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

1. Identifying information used to locate and maintain contact with the member;
2. Case opening – after receipt of referral, verification that a case was opened for assessment and service delivery;
3. Introduction to Case Management –the case manager explained the case management process to the member; and
4. Acceptance of Services –the member indicated they agreed with the MCHP providing case management services.

Figure 11 - Percentage of Case Records with Member Contact and Case Management Introduction



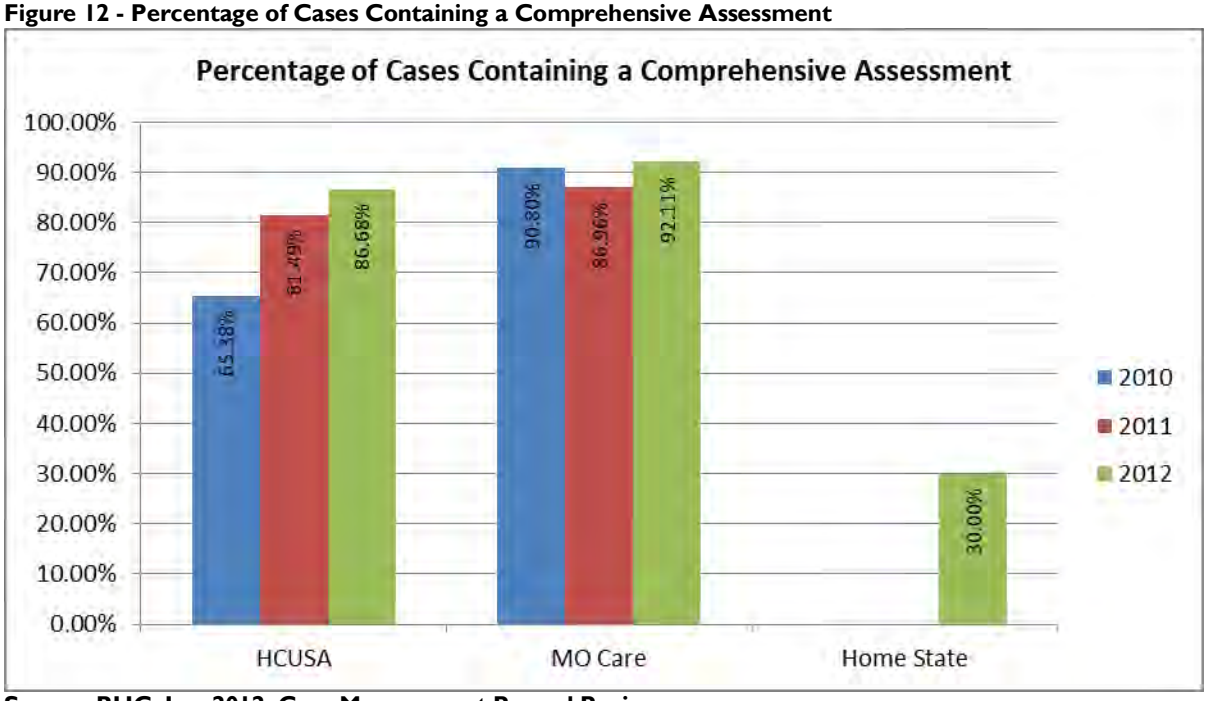
Source: BHC, Inc. 2012, Case Management Record Review

- Obtaining referrals, locating members, introducing them to the case management process, and eliciting their acceptance of case management services are essential functions for case managers.
  - Both HCUSA and MO Care improved in this area. These MCHPs' percentages increased in all four standards from 2010 to 2012. This indicates that the efforts to contact members and explain the case management process were successful.
  - Home State does not have previous experience, as they received a contract in July 2012. Their percentages indicate that they are contacting members. However, they are not always successfully engaging them into accepting case management.

- Case managers receive referrals from a variety of sources internal and external to the MCHP.
  - Members have the option of declining case management services. In most records reviewed for HCUSA and MO Care when members were contacted they welcomed the support that case management offers. In the majority of instances case management services were accepted.
- Case managers are required to explain the nature of the case management relationship, the contact they will have with the member and the services available. Case managers must request approval to discuss the case with a third party, if appropriate; discuss the availability of a complaint process; and explain any contacts with the providers involved.
  - This activity occurred in most cases that were opened and was reflected in the case record information, along with the member's agreement to accept services.
- Cases that were referred to Home State due to Elevated Blood Lead Levels (EBLL) indicated little or no member contact.
  - These cases were closed in the MCHP's system in violation of contract terms, and the case manager did not follow or track these cases to ensure that the member's blood level returned to and maintained normal levels.

ASSESSMENT

Figure 12 - Percentage of Cases Containing a Comprehensive Assessment



Source: BHC, Inc. 2012, Case Management Record Review

The standards used to evaluate the assessment of the member's service needs include:

1. Completion within specified time frames; and

2. Inclusion of a comprehensive assessment in the file.

- All records/or progress notes must include an assessment tool, questions, and member response.

  - In HCUSA and MO Care records the assessment tool or questions were found in more case records in 2012 than in previous years.

  - The records from Home State did provide assessment information in thirty percent (30%) of their records. The inclusion of the assessment tool, or narrative comments regarding assessment results was sporadic and lacked consistency across all service types.

- These assessments are to be comprehensive in nature for all MCHPs. This requirement did improve in 2012.

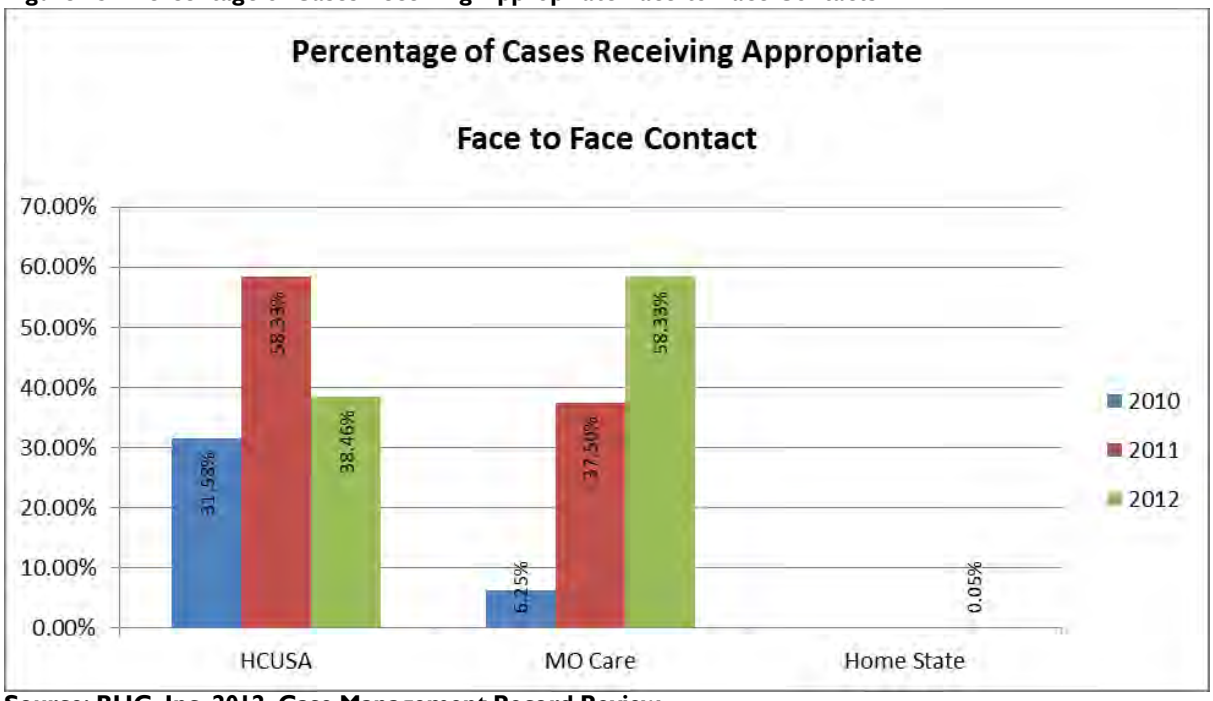
  - In the cases that included assessment tools, standardized questions were asked of all members. Notes were often included in HCUSA and MO Care cases indicating that the case manager evaluated the answers and utilized this information in the work with the member. This was not found in past reviews.

  - In Home State cases, a brief Health Risk Assessment could be found in eighteen (18) cases. During the on-site interviews case managers explained that this form is used by the intake staff to evaluate if the member is a candidate for case management services. If the member qualifies for case management the intake staff uses the Health Risk Assessment to assign potential risk. The actual comprehensive case management assessment was only available in nine (9) of the records reviewed.

  - There continues to be a disconnect between members indicating a need for behavioral health services, or even admitting that they had behavioral health issues during the assessment, and follow through with referrals to a behavioral health provider. It should be noted that MO Care provides a coordinated system of services and an integrated approach to ensuring referrals between physical health and behavioral health.

FACE-TO-FACE CONTACTS

Figure 13 - Percentage of Cases Receiving Appropriate Face-to-Face Contacts



Source: BHC, Inc. 2012, Case Management Record Review

Although the contract language regarding the need to provide face-to-face visits changed slightly, it still contains the expectation that these visits will be made in most cases.

- MO Care showed improvement in this area.
- HCUSA had a significant decrease in the number of cases where face-to-face contacts occurred.
  - In the OB/Perinatal cases reviewed, only one of ten indicated that face-to-face contacts had occurred or had been requested. This is a serious deficiency in attention to service requirements for these cases.
- Home State did not include referrals to third party providers for face-to-face visits in most cases. There were no referrals for face-to-face visits in OB/Perinatal cases, and only one (1) in lead case management. This is an area where the MCHP needs immediate corrective action.
  - The MCHP contracts with several agencies to complete in-home or face-to-face contacts. If this is occurring it is not reflected in the case managers' progress notes. In the cases reviewed this information was not available.
  - Case managers reported that they know they can refer to outside agencies, and have done so to locate members. They seemed unaware that they can authorize face-to-face contacts for members in OB/Perinatal cases or that this is a requirement in lead cases.

- All three MCHPs report that they do not directly conduct face-to-face contacts with members. They contract for this service. It appears that more referrals and consistent follow-up are

required in this area. In addition, information from the contracted agency about member contacts must appear in progress notes.

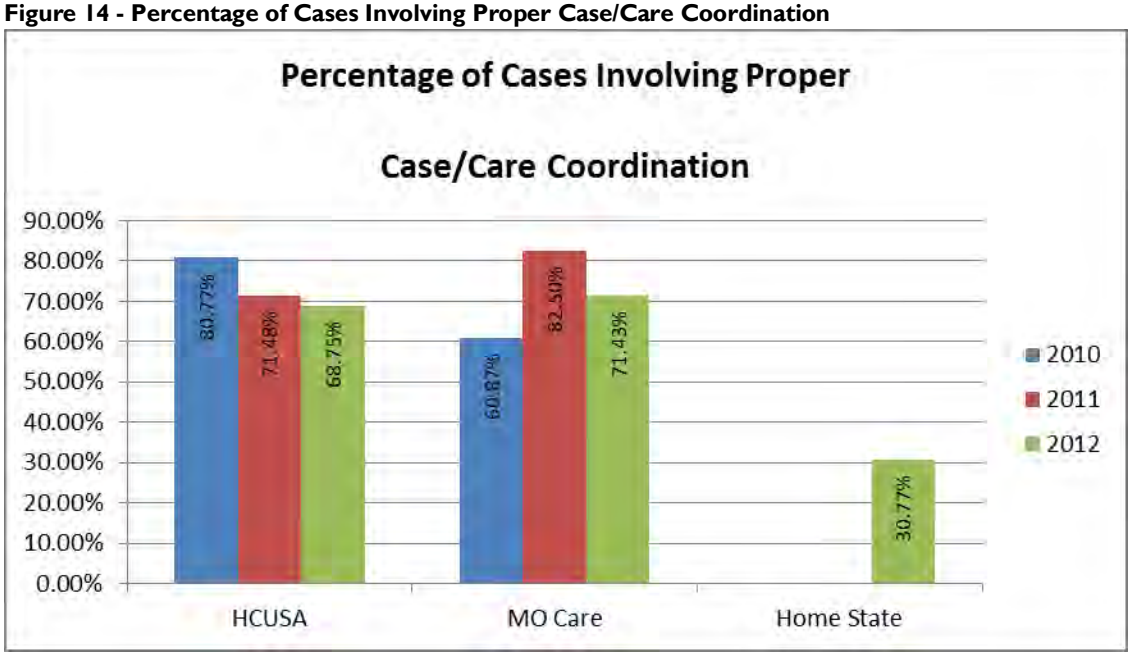
CASE/CARE COORDINATION

There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members.

2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.

Figure 14 - Percentage of Cases Involving Proper Case/Care Coordination



Source: BHC, Inc. 2012, Case Management Record Review

- HCUSA and MO Care both decreased in this service area in 2012. HCUSA declined for the second straight year. There is very little attention in progress notes to the need for reporting on case coordination.

- An area of concern is the number of cases reviewed where behavioral health services seemed appropriate. These cases involved a report of depression or a bi-polar condition during the assessment, where no follow-up, offer of referral for services, or a direct referral as the result of a serious situation regarding the member's admitted problems was found.

  - Home State admitted that this was an area of evolving competency. They are working on better recognition of the need for behavioral health services and a better method of making referrals.

- When the MCHPs successfully recognized and acted upon the members' needs for complex case management, there was active coordination of care.

CONCLUSIONS

The EQRO is tasked with reporting how Managed Care members access care, the quality of care participants receive and the timeliness of this care. CMS requests that the EQRO report on those three areas of care in each area of validation.

QUALITY OF CARE

- When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate for extraordinary services to meet members' needs.
  - In 2012, reviewers observed improvement in this area HCUSA and MOCare. At these MCHPs, case management services provided referrals and communicated with the physicians or their staff regularly. Case managers assisted members in achieving their goals and stabilizing their health care conditions. They used MCHP sponsored services, linked members to community resources, and ensured the outcome of improved member health.
  - At Home State case managers are learning what is expected of them. They are seeking to familiarize themselves with available services through the MCHP and to be more involved in ensuring members obtain quality health care services.
- In case records indicating contact with the physician's office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.
  - These cases included many contacts with the physician's nurse or nurse practitioners.
  - Physicians responded directly to inquiries and questions from the case managers.
  - When contacts occur the case notes indicate better and more complete service delivery.
- A number of issues that impact quality were observed that continue to need improvement. These include:
  - Informing or including the PCP in care plan development;
  - Ensuring that all members who need face-to-face contacts have access to this service;

- Completing and communicating a transition plan with members that provide direction and information; and
- Informing the PCP and other providers when case management ceases.

➢ Quality of care is improved when services occurred as seen in the cases opened as the result of Emergency Department referrals (HCUSA and MO Care only).
- Case managers identified members as High Risk OB cases. Ongoing case management and ancillary services began immediately.
- Members with multiple issues and complex cases were identified and case management initiated.

➢ In the area of lead case management, member's quality of care was negatively affected.
- Home State was not providing the type or depth of services expected.
  - Less than one half of the cases reviewed were actually opened for services or follow-up care. The EQRO is concerned about this MPHC's understanding of the lead case management program.
    - Only one case included home visits or face-to-face contacts as required.
    - Few or no contacts were made with the member or the member's parent/guardian.
    - There was very little evidence of lead case managers contacting public health departments, Federally Qualified Health Centers (FQHCs), schools, public agencies, or other sources that may have contact with members so they could be located and served.
    - Follow-up with and knowledge about the public health agencies involved in lead abatement and intervention was minimal.

ACCESS TO CARE

➢ Access to care was enhanced in the cases where case managers actively worked with families. In a number of cases reviewers observed creative and relentless efforts to locate members. Some of the MCHPs utilize contractors who "drive by" members' reported addresses to learn if the member is actually living there and to obtain forwarding information whenever possible. The case managers contact a variety of sources to track members' whereabouts and make required contacts.

➢ Access is improved by case managers' efforts to obtain services, community based or by providers, which uniquely met members' needs.

- Members with complex needs and high risk cases were maintained even while they briefly lost eligibility (HCUSA and MO Care). If these members regained eligibility, continuity of case management services was maintained. In two cases members were followed until another case management or service provider was identified to continue work with the member or the family.

- Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB and a first visit to the pediatrician for the baby.

- The following problems were observed and had a less desirable effect on members' access to services and health care:
  - Case managers lost contact with members who had newborns at the end of the case management process and no transition plan was developed.
  - Face-to-face contacts did not occur as required, even when a contracted provider was involved. The member did not receive services needed. This negatively impacted health care outcomes.
  - When consistent case/care coordination occurred case managers avoided duplication of services and maximized MCHP resources. However, a lack of these practices negatively affected members' access to care and was evident in many cases.
  - A lack of commitment to members who are difficult to locate or contact was observed in some cases.
    - Cases were received that were only open long enough to make three contacts and then closed. This was not a majority of the cases for HCUSA and MO Care. Home State did not have a consistent practice to locate members. The processes described by Home State staff during the on-site interviews indicated a lack of understanding or few creative approaches to finding and engaging members.
    - It is imperative that the MCHPs use a consistent approach when attempting to contact members. This will ensure good access to healthcare services.

TIMELINESS OF CARE

When case managers are actively serving a member: fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- When case management occurred in the OB cases reviewed (including the sixty (60) days postpartum,) follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. Parents who received case management services often enrolled their babies with the MCHP and ongoing preventive care could occur.

- Home State case management, as previously noted often ended right after the baby's birth in OB cases.

- Case managers continue to report that they are unable to create a useful transition plan with the member when it appears the case should be closed.
  - Case managers assert that after members' health care needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager. Cases are then closed using the approved standard closing letter with no case specific plan included. This was found less often at HCUSA and MO Care than in previous years.
  - Lack of effort to create transitional planning or follow-up with the member creates a situation where significant healthcare issues resurface due to unachieved goals.

- Information sharing with PCP offices and sending a letter at case closing requires improvement.
  - Case managers' lack of attention to proper case closure negatively impacts members' ability to obtain needed services in a timely manner.
  - Case notes reflect that in many instances instructions are given to the member, with the hope that they will take responsibility for follow-up and timely self-care.
    - The case managers admit that when they have a relationship with the physician's office it is beneficial to their work with the member.
    - Timeliness is greatly improved by ensuring that members, particularly members with special health care needs, obtain all necessary medical services with some oversight.

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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care…that is designed, conducted and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each MCHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2012. This included evaluating the Statewide Project entitled "Improving Oral Health." The Statewide Project's aggregate report was the foundation of each individual MCHP's PIP. These responses and interventions were examined as individual PIPs.

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by MCHPs during the calendar year 2012. The MCHPs were to have two active PIPs available for evaluation, one clinical and one non-clinical. The validation process examines the stability and variability of change over multiple years. The evaluation in 2012 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each MCHP for the remeasurement year. For the Statewide PIP, each MCHP developed and implemented individualized interventions to create improved outcomes for their members.

2.3 Findings

The PIPs identified for validation at each MCHP are:

HealthCare USA	Readmission Performance Improvement Project Improving Oral Health
Home State Health Plan	Notification of Pregnancy Form Receipt Improvement Improving Oral Health
Missouri Care	Comprehensive Diabetes Care Improving Oral Health

The findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects are located in Table 1.

Table 1 – Performance Improvement Validation Findings, by MCHP

Performance Improvement Projects Validation Findings, by Health Plan									
Steps		HCUSA			Home State			MO Care	
		Readmission PIP	Improving Oral Health		Notificaiton of Pregancy Forms	Improving Oral Health		Comprehensive Diabetes Care	Improving Oral Health
1: Selected Study Topics	1.1	2	2		2	2		2	2
	1.2	2	2		2	2		2	2
	1.3	2	2		2	2		2	2
2: Study Question	2.1	2	2		2	2		2	2
3: Study Indicators	3.1	2	2		2	2		2	2
	3.2	2	2		2	2		2	2
4: Study Population	4.1	2	2		2	2		2	2
	4.2	2	2		2	2		2	2
5: Sampling Methods	5.1	NA	NA		NA	NA		NA	NA
	5.2	NA	NA		NA	NA		NA	NA
	5.3	NA	NA		NA	NA		NA	NA
6: Data Collection Procedures	6.1	2	2		1	2		2	2
	6.2	2	2		2	2		2	2
	6.3	2	2		1	2		2	1
	6.4	2	2		1	2		2	1
	6.5	2	2		2	1		2	1
	6.6	2	2		2	1		2	2
7: Improvement Strategies	7.1	2	2		2	1		2	2
8: Analysis and Interpretation of Study Results	8.1	2	2		2	NA		2	2
	8.2	2	2		2	NA		2	2
	8.3	2	2		2	NA		2	2
	8.4	2	2		2	NA		2	2
9: Validity of Improvement	9.1	2	2		NA	NA		2	2
	9.2	2	2		NA	NA		2	2
	9.3	2	2		NA	NA		NA	2
	9.4	2	2		NA	NA		NA	2
10: Sustained Improvement	10..1	NA	2		NA	NA		2	2
Number Met		23	24		16	12		22	21
Number Partially Met		0	0		3	3		0	3
Number Not Met		0	0		0	0		0	0
Number Applicable		23	24		19	15		22	24
Percent Met		100%	100%		84.21%	80.00%		100.00%	87.50%

STEP 1: SELECTED STUDY TOPICS

Study topics are selected through data collection and the analysis of comprehensive aspects of member needs, care, and services. They are to address a broad spectrum of key aspects of member health care needs. In all cases the topics are to include all enrolled populations pertinent to the study topic without excluding members with special health care needs. In 2012 the clinical PIPs addressed: decreasing post-hospitalization readmissions; increasing early notification and initiation of services to pregnant women; and improving comprehensive diabetes care. All three non-clinical projects addressed improving oral health through MCHP specific interventions, as extensions of the Statewide PIP.

Table 1 shows the ratings for each item and PIP by MCHP. All six PIPs provided a rationale demonstrating the extent of the need for the PIP and provided information to support selection of the study topic. Table 2 provides a summary of the PIP ratings by Item for all MPHCs. All Study Topic presentations employed a literature or research review that supported the planned performance improvement activities. This research provided some benchmark comparison data. This section met the study methodology criteria required 100% of the time. All of the MCHPs addressed a broad spectrum of key aspects of member care and services (100.0%). Each MCHP submitted one clinical and one non-clinical intervention for review. An array of the aspects of enrollee care and services were included in these studies. (Steps 1.1 and 1.2)

Utilization or cost issues may be examined through a PIP, but are not to be the sole focus of any study. There were descriptions of the member populations targeted for intervention in the PIPs. These three MCHPs focused only on the Managed Care member populations, although parent companies may serve a variety of additional populations. The PIPs reviewed in 2012 were all developed to enhance services to the Managed Care members served. In addition, PIPs should specifically indicate whether all enrolled populations within the MO HealthNet Managed Care Program are included in the interventions. Finally, age and demographic characteristics should be described. All six PIPs "Met" these criteria (Step 1.3).

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MCHPs made a concerted effort to ensure that statements were provided in the form of a question, and the

questions were directly related to the hypotheses and topic selected. Six of the PIPs included clearly stated and goal directed study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in the studies presented.

Table 2 – Summary of Performance Improvement Project Validation Ratings by Item, All MCHPs

	ALL HEALTH PLANS					
Step	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	6	0	0	6	100.00%
	1.2	6	0	0	6	100.00%
	1.3	6	0	0	6	100.00%
Step 2: Study Questions	2.1	6	0	0	6	100.00%
Step 3: Study Indicators	3.1	6	0	0	6	100.00%
	3.2	6	0	0	6	100.0%
Step 4: Study Populations	4.1	6	0	0	6	100.00%
	4.2	6	0	0	6	100.00%
Step 5: Sampling Methods	5.1	NA	0	0	0	NA
	5.2	NA	0	0	0	NA
	5.3	NA	0	0	0	NA
Step 6: Data Collection Procedures	6.1	5	1	0	6	83.33%
	6.2	6	0	0	6	100.00%
	6.3	4	2	0	6	66.67%
	6.4	4	2	0	6	66.67%
	6.5	4	2	0	6	66.67%
	6.6	5	1	0	6	83.33%
Step 7: Improvement Strategies	7.1	5	1	0	6	83.33%
Step 8: Analysis and Interpretation of Study Results	8.1	5	0	0	5	100.00%
	8.2	5	0	0	5	100.00%
	8.3	5	0	0	5	100.00%
	8.4	5	0	0	5	100.00%
Step 9: Validity of Improvement	9.1	4	0	0	4	100.00%
	9.2	4	0	0	4	100.00%
	9.3	3	0	0	3	100.00%
	9.4	3	0	0	3	100.00%
Step 10: Sustained Improvement	10.1	2	0	0	2	100.00%
Number Met		**117**	**9**	**0**	**126**	**92.86%**

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.

Source: BHC, Inc., 2012 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

During past EQRs most MCHPs produced PIPs that "Met" the criteria for defining and describing the calculation of study indicators. In 2012, all six PIPs met the criteria for using objective, clearly defined, and measurable indicators (Step 3.1). In these PIPs the calculation of measures was described and explained. Even when well-known measures were used (e.g., Healthcare Effectiveness Data and Information Set—HEDIS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Because MCHPs vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. Both HCUSA and MO Care have experience in the development and presentation of this aspect of their PIPs. Home State Health Plan (Home State) did request some technical assistance but presented well documented information on the use of their indicators. It should be noted that Home State does not have HEDIS data available as they were in their first six months of operation. However, they developed data measures based on their own operations that provided confidence that they were preparing and reporting on reliable study indicators. All six PIPs identified and detailed at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. The link between the interventions and the outcomes measured by these PIPs was explicit in the narratives presented.

STEP 4: STUDY POPULATIONS

The MCHPs successfully met the criteria for adequately defining the study population. This step asks if all Managed Care members to whom the study question(s) and indicator(s) were relevant are included. All MCHPs included adequate information that allowed the EQRO to make this determination (Step 4.1). The selection criteria clearly described the Managed Care member populations included in the PIPs and their demographic characteristics. All six PIPs described data collection approaches indicating that data for all members to whom the study questions applied were collected (Step 4.2). A description was presented in the narratives reviewed that allowed inference of how data were collected and how participants were identified.

STEP 5: SAMPLING METHODS

None of these PIPs employed true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) should be described if utilized. This was not required in any of the PIPs presented for 2012.

STEP 6: DATA COLLECTION PROCEDURES

Five of the six PIPs (83.33%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). All six PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). The evaluators looked for a methodology that provides a structure for reporting measures and data sources. In some instances there is more than one source of data. It is important that the MCHP specifically state the sources of data for each measure. The MCHPs generally provided adequate narrative and explanation to allow for validation of each PIP. Four of the six PIPs (66.67%) clearly described systematic and reliable methods of data collection (Step 6.3). There was some description of the data collection procedures in all cases. It is not possible to judge the reliability or credibility of any PIP without sufficient detail regarding data collection processes, procedures, or frequency. Four of the PIPs used a data collection instrument that was described in detail. This step requires that data be presented utilizing instruments that allow consistent and accurate data collection over time (Step 6.4). Four of the PIPs (66.67%) met this element of the required study submissions. Two MCHPs (Home State and MO Care) did not provide enough information in one of their PIP narratives to create adequate confidence that consistent and accurate data would be collected and reported. Each of these MCHPs had one element that was "Partially Met."

Four of the six PIPs (66.67%) included a complete data analysis plan, while two PIPs were rated "Partially Met" (Home State and MO Care) for specifying a prospective data analysis plan (Step 6.5). The prospective data analysis plan should be developed prior to the implementation of the PIP, be based on the study questions, explain the anticipated relationship between the intervention(s) and outcome(s) being measured (i.e. independent and dependent variables); include the method(s) of data collection; and describe the nature of the data (e.g., nominal, ordinal, scale). The two PIPs rated as "Partially Met" failed to supply adequate information to meet this requirement.

Five of the six (83.33%) PIPs identified the project leader and the leader's qualifications in the narrative submitted. They identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). MCHP staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. One PIP only gave the name of the project leader for the non-clinical PIP. No information was provided about this individual's qualification or role and responsibilities regarding the project. No other team members were identified.

STEP 7: IMPROVEMENT STRATEGIES

Five of the six (83.33%) PIPs included reasonable interventions to address the barriers identified through data analysis and the quality improvement processes undertaken. One of the PIPs included interventions coded as "Partially Met" in this requirement. This PIP (Home State) did not include any narrative explanation regarding their interventions or the arguments for the intervention choices.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Five of the six PIPs (83.33%) were mature enough to include data analysis. The five PIPs that were in place long enough to allow the MCHP to conduct an analysis were analyzed according to the data analysis plan (Step 8.1). The non-clinical PIP conducted by Home State was not in place for sufficient time to analyze data. In these five PIPs there was a complete and thorough analysis of the data presented. These PIPs presented baseline and re-measurement data. In the clinical PIP conducted by Home State there was a monthly analysis presented. All numerical findings were provided accurately and clearly (Step 8.2). Axis labels and units of measurement should be reported in Tables and in Figures. The legends accompanying this information should be clearly identifiable to the reader. All tables should be part of the body of the PIP and include a narrative explanation of the results. This occurred throughout these five PIPs.

Five of the PIPs presented at least one re-measurement period that included data for all of the measures identified in the study (Step 8.3). These five presented findings describing the effectiveness of their interventions (8.4). The Home State PIP included information for the months it was in effect, and showed adequate results related to the interventions used to create change even though this project was only in place for six months.

STEP 9: VALIDITY OF IMPROVEMENT

Four of the six PIPs used re-measurement points. Four of these PIPs (100%) used the same method at re-measurement as used in the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistently with the re-measurement method to ensure validity of reported improvement and comparability of the measurement over time. The same source of data used in the baseline measure should be used at each re-measurement point.

The two PIPs reviewed for Home State Health Plan were not mature enough to conduct this level of analysis.

The four PIPs (100%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show improvement over the re-measurement points available. This improvement was not always statistically significant. The three PIPs (100%) that reported improvements had face validity, meaning that the reported improvement was judged as related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by the health plans. Additional narrative in this area would ensure proper evaluation of all data and information provided. When reporting findings some interpretation of the relationship of the intervention, or other factors, to the outcomes must occur. This information should note improvement, decline, or lack of change as the result of the interventions introduced. Three of the PIPs (100%) reached a level of maturity to include this data, and provided statistical evidence that the observed improvement was true improvement (Step 9.4). Barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described.

The clinical PIP presented by MO Care has recently experienced some negative results. The MCHP believes that they can develop interventions that lead to success and that will positively impact member behavior. This is a continuing PIP and complete analysis is not yet available.

STEP 10: SUSTAINED IMPROVEMENT

Three of the PIPs (100%) were able to make an assessment regarding sustained improvement. Two were able to demonstrate repeated measurements over time that created confidence in the sustainability of the improvements achieved. These PIPs used statistical significance testing to demonstrate improvement. The PIPs reaching this level of maturity provided arguments for continuing the improvement efforts leading to success, and their reasoning for maintained sustainability. The clinical PIP presented by MO Care included documentation that indicated a change in approach which had real promise to regain and sustain improvements gained earlier. All three MCHPs stated that they would be incorporating the processes developed during the PIPs into their routine operations as they achieve positive results.

Across all MCHPs the range in proportion of criteria that were "Met" for each PIP validated was 80% through 100%. Across all PIPs validated statewide, 92.86% of criteria were met. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. In most of the cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information revealed in-depth knowledge of the PIPs and detailed outcomes for the three MCHPs.

The PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that the MCHPs intended to use this process to improve organizational functions and the quality of services available or delivered to members. In at least three cases, the PIP had already been incorporated into MCHP daily operations. PIPs should be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the MCHP regarding the need to address barriers to implementation. MCHP personnel involved in PIPs had experience in clinical service delivery, quality improvement, and monitoring activities. It was clear, in the PIPs reviewed, that the MCHPs had made a significant investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, all of the MCHPs had active and ongoing PIPs as part of their quality improvement programs. Although the newest MCHP (Home State) did not have long term results to report, they have made an effort to utilize the PIP process to identify and resolve issues that impact member services. HCUSA submitted exemplary PIPs.

An improved commitment to the quality improvement process was observed during the on-site review at the three MCHPs. The three PIPs (Table 3) rated with "High Confidence" are on-going and active PIPs. These projects were presented well and exhibited excellent planning and reporting. Even though they are not complete, the information presented was methodologically sound and the results of their success are attributed to the interventions employed.

Table 3 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Readmission Performance Improvement Project (HCUSA)	High Confidence
Improving Oral Health (HCUSA)	High Confidence
Notification of Pregnancy Form Receipt (Home State)	NA
Improving Oral Health (Home State)	NA
Comprehensive Diabetes Care (Mo Care)	NA
Improving Oral Health (Mo Care)	High Confidence

Note: Not Credible = There is little evidence that the study will or did produce results that could be attributed to the intervention(s); Low Confidence = Few aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); High Confidence = The PIP study was conducted or planned in a methodologically sound manner, with internal and external validity, standard measurement, and data collection practices, and appropriate analyses to calculate that there is a high level of confidence that improvements were a result of the intervention. A 95% to 99% level of confidence in the findings was or may be able to be demonstrated.
Source: BHC, Inc., 2012 External Quality Review Performance Improvement Project Validation.

At the onset of each review year the MCHPs are asked to submit a listing of all PIPs underway during the previous year. These submissions created an area of concern for HCUSA and MO Care.

- HCUSA submitted a listing of five (5) PIPs, three of which were clinical. They had not developed a new clinical PIP since 2007. This is a large MCHP with a large membership. It is a real concern that HCUSA has not identified a new clinical issue in over five years.

- MO Care submitted a listing of 28 PIP topics. Four of these were clinical. Only one, Comprehensive Diabetes Care was recent – it was initiated in 2010. During this review year MO Care did request technical assistance in the area of topic development and classification.

Home State did submit both a clinical and non-clinical PIP initiated in their first six months of operation.

The following summarizes the EQRO findings regarding quality, access, and timeliness of care. This assessment and the recommendations are based on the EQRO findings during the Validation of Performance Improvement Projects.

Access to Care

Access to care was an important theme addressed throughout the PIP submissions. A major goal of the statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual oral health PIPs developed by each MCHP. Access to care was also an important focus in the clinical PIPs. Each of the MCHPs focused on assisting and educating members in developing PCP and specialist relationships. This is in an effort to obtain access to healthcare. These PIPs had a significant focus on providing access to the correct medical provider through a variety of interventions. All the projects reviewed used the format of the PIP to improve access to care for members. The clinical topics focused on early access to prenatal care; improved outreach and in-home services for members leaving the hospital; and improved prevention and primary care for members with diabetes. The on-site discussions with MCHP staff indicated they realize that improving access to care is an ongoing aspect of all projects that are developed.

Quality of Care

Topic identification was an area that provided evidence of the attention paid to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP or in the direct provision of services delivered. The corresponding interventions that addressed barriers to quality care and health outcomes were clearly evident in the narratives submitted, as well as in the discussions with the MCHPs' staff during the on-site review. These interventions addressed key aspects of enrollee care and services, such as: use of additional case management and in-home service; monitoring provider access and quality service provision; and preventive care. These efforts exemplified an attention to quality healthcare services.

Timeliness of Care

Timeliness of care was an important aspect of the PIPs reviewed. These projects addressed early involvement in prenatal care, immediate services upon release from hospitalization, and early management of members' health when diagnosed with diabetes. These projects addressed the need for timely and appropriate care for members to ensure that services were provided in the best

environment in a timely manner. The need for timely access to preventive and primary health care services was recognized as an essential component of these projects. The MCHPs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness, as they addressed internal processes and direct service improvement.

The PIPs related to Improving Oral Health included a focus on obtaining timely screenings and recognized this is an essential component of effective preventive care.

RECOMMENDATIONS

1. The MCHPs must continue to refine their skills in the development and implementation of new Performance Improvement Projects. The expectation is that the MCHPs will identify clinical topics that need improvement and develop interventions using the PIP process to impact these issues.
2. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available as technical assistance from the SMA and the EQRO. Ensuring that a variety of topics are recognized each year and that more than one PIP is in process is essential.
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions. The PIP narrative should provide adequate information to create confidence that consistent and accurate data is collected and reported.
4. Ongoing PIPs should include new and refined interventions. Next steps should be included in the narrative and planning for all on-going PIPs. On-going PIPs should include necessary data and narrative.
5. The prospective data analysis plan should be developed prior to the implementation of the PIP, be related to the study question, explain the anticipated relationship between the interventions and outcomes being measured, include the methods of data collection, and describe the nature of the data. MCHPs should present a complete prospective data analysis plan in each PIP narrative.
6. MCHPs should ensure that adequate narrative is included with the findings to create confidence that consistent and accurate data are collected and reported.

7. The MCHPs are normally skilled at the development and presentation of their PIPs. They need to ensure that adequate narrative is presented explaining and interpreting the PIP outcomes and how these outcomes are related to the interventions employed.
8. Efforts to improve outcomes related to the Statewide PIP topic should be continued. A number of innovative approaches were used to impact access to improve oral health care. The MCHPs should continue developing and implementing individualized interventions and approaches to obtaining positive outcomes when working on this statewide topic.
9. The MCHPs are all involved in an effort to update the statewide PIP to improve its focus and goals to meet those proposed by CMS. It is recommended that all three MCHPs maintain their involvement and commitment to this process.
10. Utilize the PIPs as a tool to improve the organizations ability to serve members.

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3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MCHP. These measures are selected by MO HealthNet Division (MHD) each year. For the HEDIS 2012 evaluation period, the three performance measures selected for validation were Annual Dental Visit (ADV); Childhood Immunizations Status, Combination 3 (CIS3); and Follow-Up After Hospitalization for Mental Illness (FUH). Each of these measures has been previously reviewed by the EQRO:

- The Annual Dental Visit measure
  - HEDIS 2011, 2010, 2009, 2008, and 2007.
- The Follow-Up After Hospitalization for Mental Illness measure
  - HEDIS 2011, 2010, 2009, 2007, and 2006 review periods.
- The Childhood Immunizations Status, Combination 3 measure
  - HEDIS 2011.

Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MCHPs to analyze data; 2) Evaluation of algorithmic compliance with performance measure specifications: and 3) Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the MCHPs are based upon accurate calculations.

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of the MCHPs; and 2) determine the extent to which MCHP-specific performance measures calculated by the MCHPs (or by entities acting on behalf of the MCHPs) followed specifications established by the SMA and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

3.2 Findings

NOTE: Because HEDIS 2012 data is based on calendar year 2011 data, the Performance Measures validation included in this report will include data from the six MCHPs that were under contract with MO HealthNet during calendar year 2011. The inclusion of all six MCHPs is necessary to present a statewide picture of HEDIS 2012. Those six MCHPs include:

- Blue Advantage Plus of Kansas City (BA+)
- Children's Mercy Family Health Partners (CMFHP)
- Harmony Health Plan of Missouri (Harmony)
- HealthCare USA (HCUSA)
- Missouri Care (MO Care)
- Molina Healthcare (Molina)

Only two of the six MCHPs that were operating during the 2012 Calendar Year were still under contract with MO HealthNet at the time this review commenced. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

The method of calculation used by each MCHP is detailed in Table 4.

Table 4 – Summary of Method of Calculation Reported and Validated by MCHPs

MO HealthNet MCHP	Annual Dental Visit	Childhood Immunizations Status, Combo 3	Follow-Up After Hospitalization for Mental Illness
Healthcare USA	Administrative	Hybrid	Administrative
Missouri Care	Administrative	Hybrid	Administrative

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the status of submission of the measures validated to MHD and SPHA, the Final Audit Ratings, and conclusions.

HEDIS 2012 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2012 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. Only two of the six MCHPs that were operating during the 2012 Calendar Year were still under contract with MO HealthNet at the time this review commenced. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms.

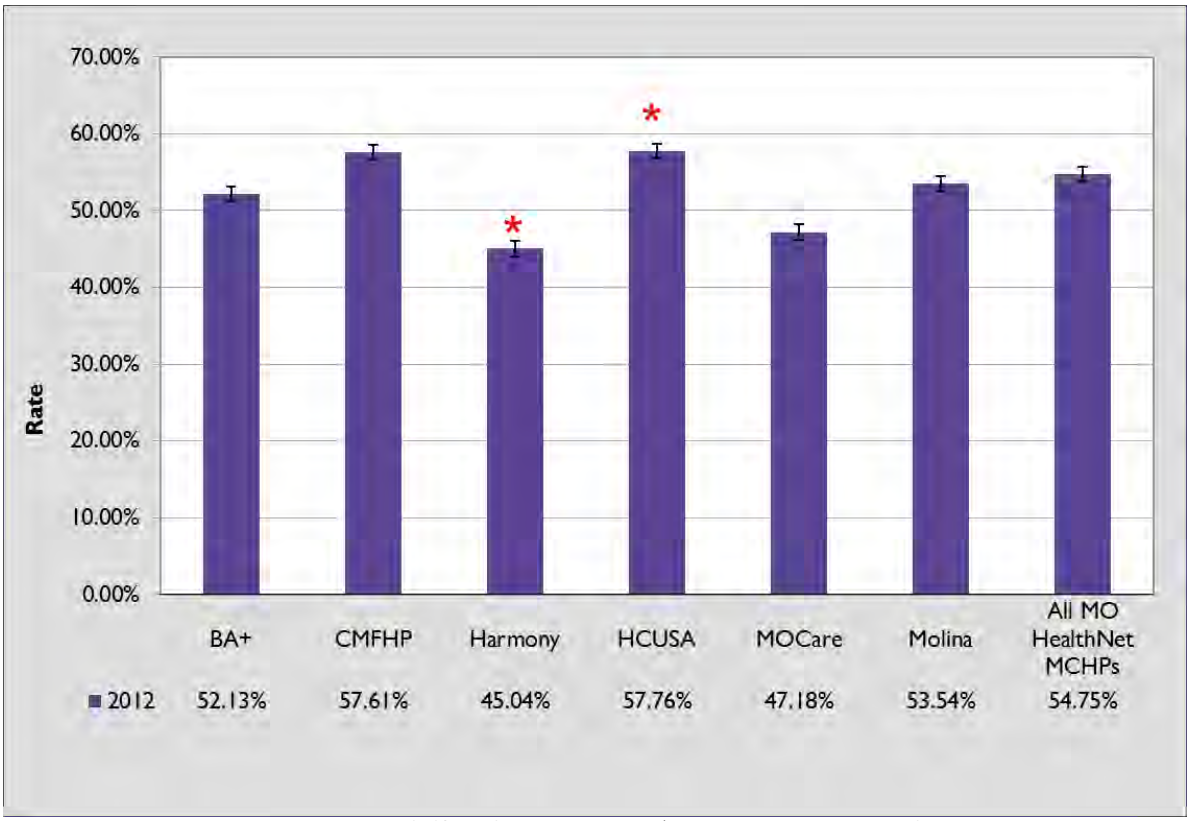
Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure.

When determining the denominator, it was expected that all MCHPs would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2012 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible members (eligible population identified / total enrollment) was calculated for all MCHPs and is illustrated in Figure 15. Two-tailed z-tests of each MCHP were conducted comparing the MCHPs to the rate of eligible members for all MCHPs at the 95% level of confidence. The percentage of eligible members identified by HCUSA (57.76%) showed a statistically **higher** rate when compared to the group average. Harmony showed statistically **lower** rate (45.04%) than the MCHP average. These differences

in rates may be due to the demographic characteristics of the member population, the completeness of claims data, or the processes of identifying eligible members.

Figure 15 – Managed Care Program HEDIS 2012 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2010 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2012 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2011.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2012 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply. Table 5 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST for the HEDIS 2012 Annual Dental Visit measure. It is the task of the EQRO to compare MCHP to MCHP on a statewide level. Therefore, for all MCHPs who reported rates by region (e.g. HCUSA and Molina), the regional numbers were combined to create a plan-wide rate.

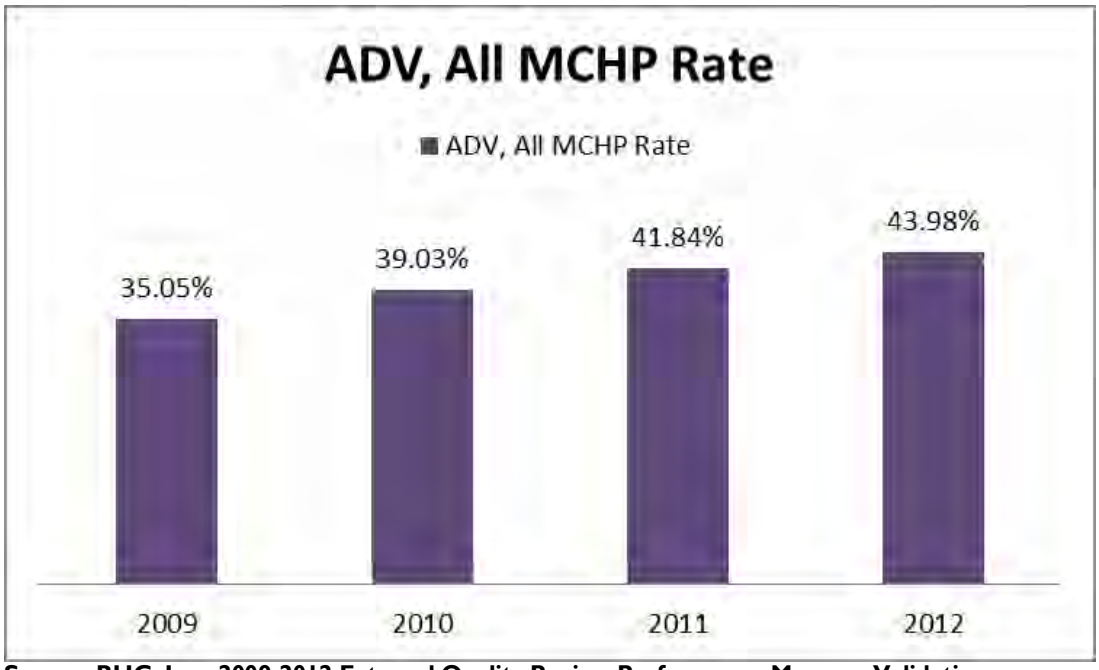
For those MCHPs that did not continue to contract with the SMA after June 30, 2012, the EQRO was unable to validate the rates reported.

Table 5 - Data Submission and Final Validation for HEDIS 2012 Annual Dental Visit (combined rate)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	15,473	5,895	38.10%	0	0.00%	0.00%
Childrens Mercy Family Health Partners	32,271	16,191	50.17%	0	0.00%	0.00%
Harmony Health Plan	7,415	1,956	26.38%	0	0.00%	0.00%
HealthCare USA	110,824	51,303	46.29%	51,303	46.29%	0.00%
Missouri Care	25,029	10,756	42.97%	10,756	42.97%	0.00%
Molina Healthcare	43,418	17,009	39.17%	0	0.00%	0.00%
All MCHPs	**234,430**	**103,110**	**43.98%**	**62,059**	**45.68%**	**0.00%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' HEDIS 2012 Data Submission Tools (DST).

Figure 16 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit

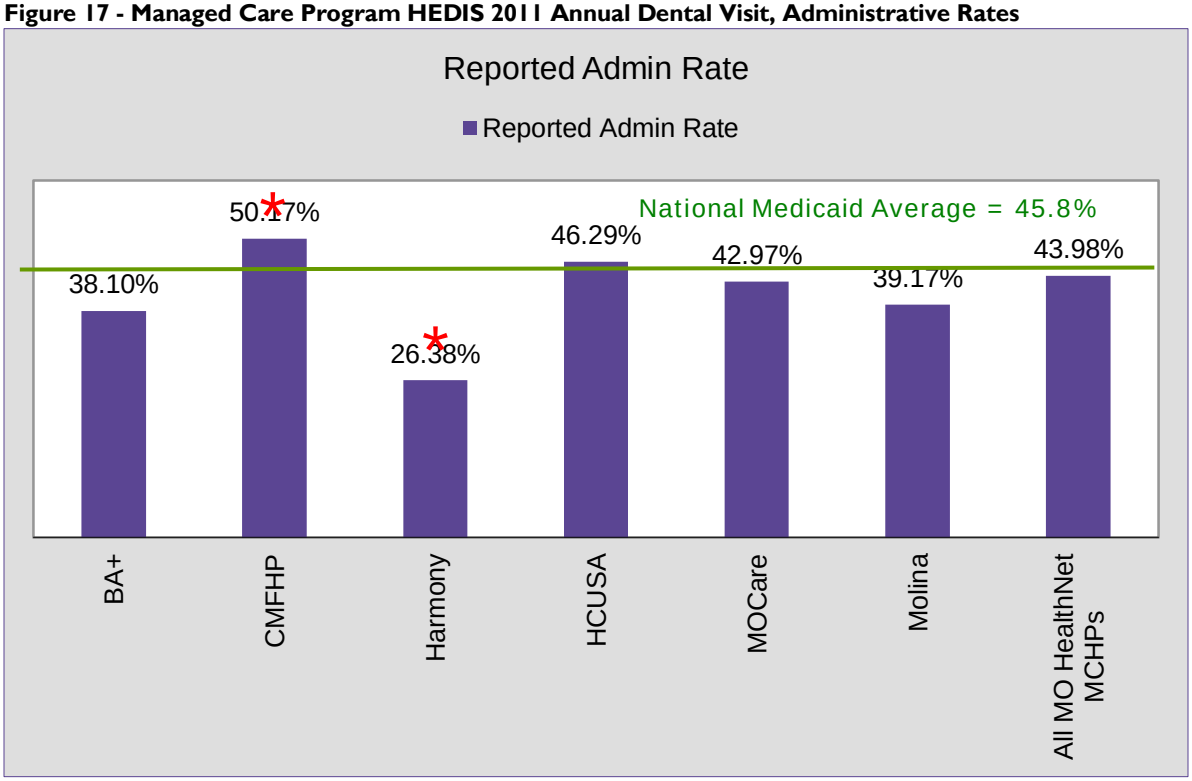


Source: BHC, Inc., 2009-2012 External Quality Review Performance Measure Validation

The Annual Dental Visit measure has been reviewed for the last six audit years, the data for the last four years: 2009, 2010, 2011, and 2012 are analyzed here (see Figure 16). The rates for all MCHPs were 35.05%, 39.03%, 41.84%, and 43.98% in 2009, 2010, 2011, and 2012 respectively. This indicates an increase in access to dental visits over time within the MO HealthNet Managed Care population. This steady increase in statewide rates is supported by the Statewide Performance Improvement Project that was discussed in Section 2 of this report.

In all of these audits, many of the MCHPs reported individual rates lower than the National Medicaid Average. The combined average rate for all MCHPs has also been lower than this average. However, the National Medicaid Average has increased over time, as has the combined rate for all MCHPs. The 2012 MCHP rates ranged from 26.38% (Harmony) to 50.17% (CMFHP; see Figure 17). HCUSA reported a rate higher than the National Medicaid Average and the average combined rate for all MCHPs.

Figure 17 - Managed Care Program HEDIS 2011 Annual Dental Visit, Administrative Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2012 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2012 Annual Dental Visit measure. All six MCHPs calculated and submitted the measure to the SPHA and SMA. All MCHPs in the State of Missouri are required to calculate and report the measure to the SPHA, and MCHPs are required to report the measure to the SMA.

Final Validation Findings

For the two MCHPs fully validated by the EQRO, no bias was found between the reported and EQRO calculated rates. Because the EQRO did not have access to the data files of the four MCHPs no longer contracted with MHD, an assumption has been made that the rates these MCHPs reported to the SPHA are/were accurate. The EQRO validated rates for the two MCHPs that remain under contract with MHD were found to be accurate and no bias exists.

HEDIS 2012 Childhood Immunizations Status, Combination 3

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources for the calculation of the HEDIS 2012 Childhood Immunizations Status measure, specifically for Combination 3. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2012 Childhood Immunizations Status Combo 3 measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. No data integration and control issues were discovered by the EQRO. Only two of the six MCHPs that were operating during the 2012 Calendar Year were still under contract with MO HealthNet at the time this review commenced. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

Documentation of Data and Processes

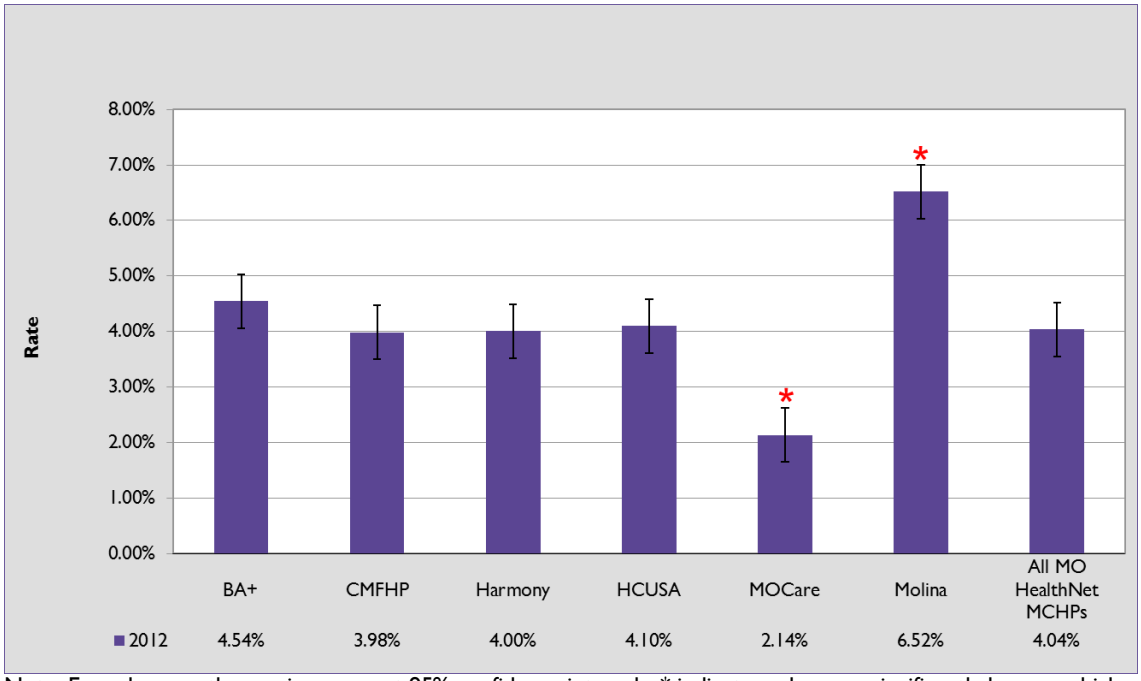
The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2012 Childhood Immunizations Status Combo 3 measure.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2012 Childhood Immunizations Status Combo 3 measure, the sources of data include enrollment, eligibility, and claim files.

Figure 18 illustrates the rate of eligible members identified by each MCHP, based on the enrollment of all Managed Care members as of December 31, 2011. It was expected that MCHPs would identify similar proportions of eligible members for the HEDIS 2012 Childhood Immunizations Status Combo 3 measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MCHPs and two-tailed z-tests of each MCHP compared to the state rate of eligible members were conducted at the 95% level of confidence. Missouri Care (2.14%) identified a rate that was significantly lower than the MCHP average (4.04%).

Figure 18 - Managed Care Program HEDIS 2012 Childhood Immunizations Status Combo 3, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2011 (the measurement year) was used to calculate the rate.
Sources: MCHP HEDIS 2012 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2011.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2012 Childhood Immunizations Status Combo 3 measure, the sources of data included enrollment, eligibility, and claim files. Table 6 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DSTs. The "combined" rates for HCUSA and Molina were calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The rate for all MCHPs was 60.74%, with MCHP rates ranging from 55.72% (CMFHP) to 62.77 % (BAPlus).

Table 6 - Data Submission for HEDIS 2012 Childhood Immunizations Status Combo 3 Measure

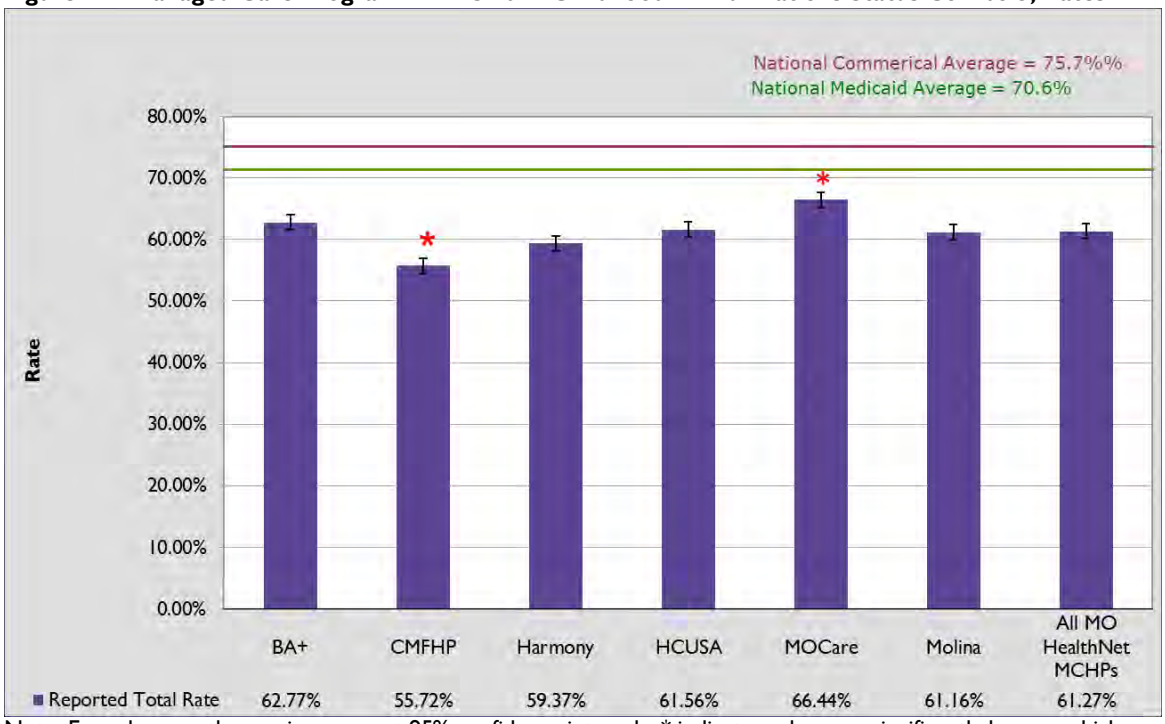
MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)
Blue Advantage Plus	Hybrid	411			258	62.77%
Childrens Mercy Family Health Partners	Hybrid	411			229	55.72%
Harmony Health Plan	Hybrid	411			244	59.37%
HealthCare USA	Hybrid	1254	496	276	772	61.56%
Missouri Care	Hybrid	432	115	172	287	66.44%
Molina Healthcare	Hybrid	1228			751	61.16%
All MO HealthNet MCHPs		**4,147**	**611**	**448**	**2,541**	**61.27%**

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The statewide rate for all MCHPs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.
Source: MO HealhtNet Ad Hoc Report

Table 6 illustrates the rates reported by the MCHPs and the rates of administrative and hybrid hits for each MCHP. The rate reported by each MCHP was compared with the rate for all MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the rate for all MCHPs were calculated at the 95% confidence interval.

The rate for all MCHPs (61.27%) was lower than both the National Medicaid rate (70.6%) and the National Commercial Rate (75.7%) (see Figure 19). The rate for MO Care (66.44%) was significantly **higher** than the overall MCHP average. CMFHP reported a rate of 55.72%, which was significantly **lower** than the statewide rate for all MCHPs.

Figure 19 - Managed Care Program HEDIS 2012 Childhood Immunizations Status Combo 3, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2012 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Each of the six MCHPs calculated the Childhood Immunizations Status measure using the hybrid method for calculation. There were no statistically significant differences between the average for all MCHPs found in these rates. Table 7 summarizes the findings of the EQRO medical record review validation. Although, all of the six MCHPs used the Hybrid Method of calculation, the EQRO was only able to validate the medical records reviewed for MO Care and HCUSA. HCUSA and MO Care operate in multiple regions; therefore, the sample sizes selected for each region were combined to represent the overall MCHP rates. A total of 60 of the 448 medical record hybrid hits reported by these two MCHPs were sampled for validation by the EQRO. Of the records requested, all 60 were received for review. The EQRO was able to validate all 60 of the records received, resulting in an Error Rate of 0% across all MCHPs. The number of False Positive Records (the total amount that could not be validated) was 0 of the 448 reported hits. This shows no bias in the estimation of hybrid rates for the MCHPs based upon medical record review. Table 8 shows the impact of the medical record review findings.

Table 7 - Medical Record Validation for HEDIS 2012 Childhood Immunizations Status Combo 3 Visits Measure

MCHP Name	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate	Weight of Each Medical Record	False Positive Records	Estimated Bias from Medical Records
HCUSA	1254	276	30	30	30	100.0%	100.0%	0.0%	0.001	0	0.0%
MOCare	432	172	30	30	30	100.0%	100.0%	0.0%	0.002	0	0.0%
All MCHPs	**1,686**	**448**	**60**	**60**	**60**	**100.0%**	**100.0%**	**0.0%**	**0.0006**	**0**	**0.0%**

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record
Source: MCHP Data Submission Tools (DST); BHC, Inc. 2012 External Quality Review Performance Measures Validation.

Table 8 - Impact of Medical Record Findings, HEDIS 2012 Childhood Immunizations Status Combo 3 Measure

Audit Elements	MCHP Name	
	HCUSA	MOCare
Final Data Collection Method Used (e.g., MRR, hybrid,)	Hybrid	Hybrid
Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	0.00%	0.00%
Is error rate < 10%? (Yes or No)	Yes	Yes
If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	Passes	Passes
If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA
Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	1254	432
Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA
Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA
Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA
Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MCHP; Administrative Method was used by the MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.
Source: BHC, Inc. 2012 External Quality Review Performance Measure Validation.

Across the two MCHPs, 100% of the applicable criteria for calculating numerators were met. Each of the MCHPs met the criteria for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, eliminating or avoiding double-counting members, and following applicable time parameters. All of the MCHPs calculated this measure using the Hybrid method, and each met all criteria (100.0%) relating to medical record reviews and data. The MCHPs met 100% of criteria for calculating the numerator for the HEDIS 2012 Childhood Immunizations Status, Combination 3 measure.

Sampling Procedures for Hybrid Method

The objective of this activity was to evaluate the MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Across all MCHPs, the criteria for sampling were met 100.0% of the time. All MCHPs used the Hybrid Method of calculating the HEDIS 2012 Childhood Immunizations Status Combination 3 measure and all met 100.0% of the criteria for proper sampling.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2012 Childhood Immunizations Status Combination 3 measure. All MCHPs reported the measure to the SPHA and SMA.

Final Validation Findings

The two MCHPs that the EQRO was fully able to review, both received a rating of Substantially Compliant with the CIS 3 Performance Measure. No bias was found in the rates reported by these two MCHPs.

HEDIS 2012 Follow-Up After Hospitalization for Mental Illness

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. Only two of the six MCHPs that were operating during the entire 2012 Calendar Year are still under contract with the State of Missouri. Thereby, only these two MCHPs were subject to the full validation of Performance Measure Data. These two MCHPs met all criteria for every audit element.

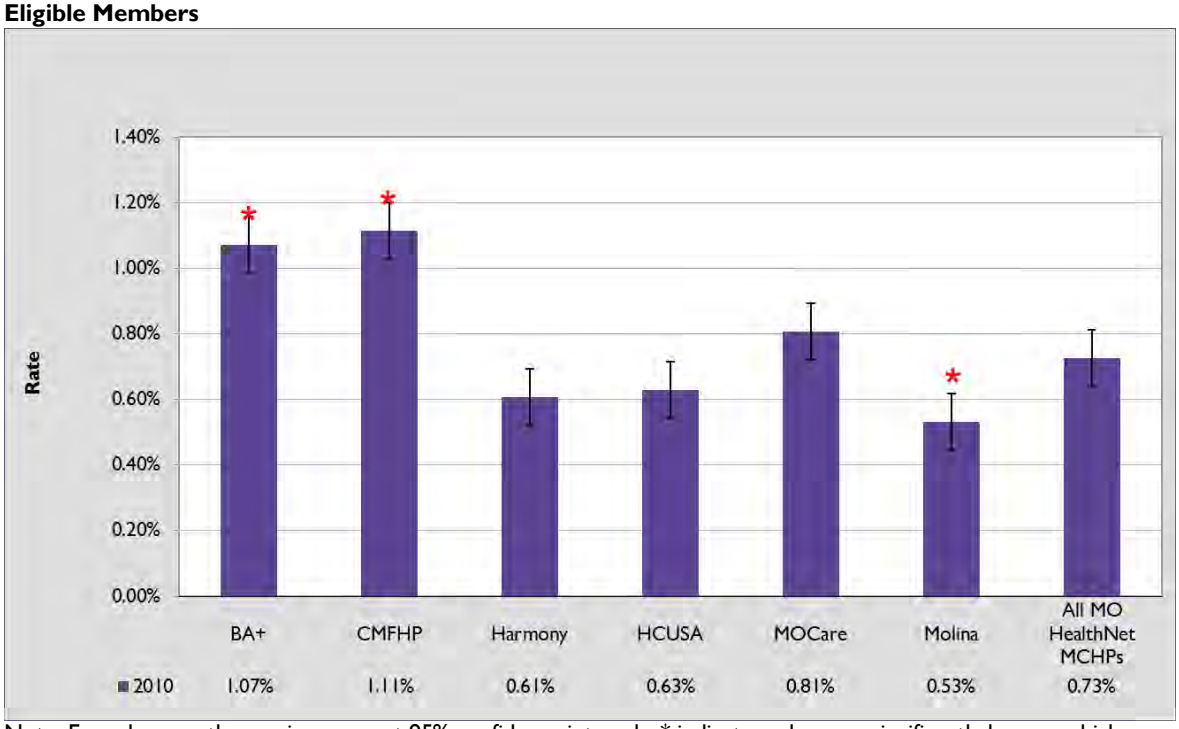
Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. Figure 20 illustrates the rate of eligible members per MCHP based on the enrollment of all Managed Care Waiver Members as of December 31, 2011. It was expected that MCHPs would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the state rate of eligible members for all MCHPs were calculated at the 95% level of confidence. HCUSA and MO Care both had a rate of eligible members that was consistent with the all MO HealthNet MCHPs average.

Figure 20 - Managed Care Program HEDIS 2012 Follow-Up After Hospitalization for Mental Illness, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2010 (the measurement year) was used to calculate the rate.
Sources: MCHP HEDIS 2012 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division , State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2012.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the MCHP's ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2012 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 9 and Table 10 show the numerators, denominators, rates, and confidence intervals submitted by the MCHPs to the SPHA on the DST for the Follow-Up After Hospitalization for Mental Illness measure. HCUSA and Molina reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a plan-wide combined rate.

Table 9 - Data Submission and Final Data Validation for HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure (7 days)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	318	235	73.90%	0	0.00%	0.00%
Childrens Mercy Family Health Partners	624	344	55.13%	0	0.00%	0.00%
Harmony Health Plan	100	43	43.00%	0	0.00%	0.00%
HealthCare USA	1,207	599	49.63%	598	49.54%	0.08%
Missouri Care	428	173	40.42%	173	40.42%	0.00%
Molina Healthcare	432	122	28.24%	0	0.00%	
All MCHPs	**3,109**	**1,516**	**48.76%**	**771**		

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: Managed Care Organization HEDIS 2012 Data Submission Tools (DST).

Table 10 - Data Submission and Final Data Validation for HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure (30 days)

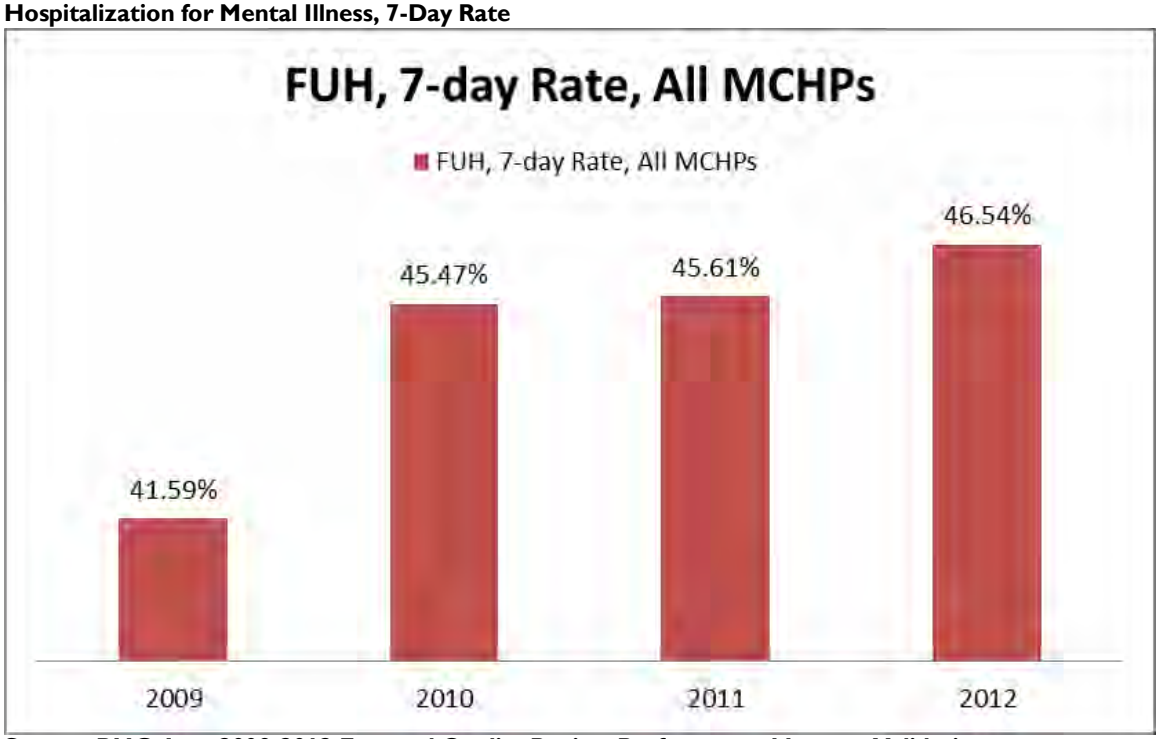
Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	318	166	52.20%	0	0.00%	0.00%
Childrens Mercy Family Health Partners	624	488	78.21%	0	0.00%	0.00%
Harmony Health Plan	100	63	63.00%	0	0.00%	0.00%
HealthCare USA	1,207	865	71.67%	865	71.67%	0.00%
Missouri Care	428	204	47.66%	204	47.66%	0.00%
Molina Healthcare	432	237	54.86%	0	0.00%	0.00%
All MCHPs	**3,109**	**2,023**	**65.07%**	**1,069**		

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: Managed Care Organization HEDIS 2012 Data Submission Tools (DST).

This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, 2010, and 2011, the analysis contained here will include 2009-2012 data (see Figure 21).

The 7-Day reported rate for all MCHPs in 2012 (46.54%) was only a 0.93% point increase over the rate reported in 2011 (45.61 %), but was an increase of 4.95% points over the 2009 rate.

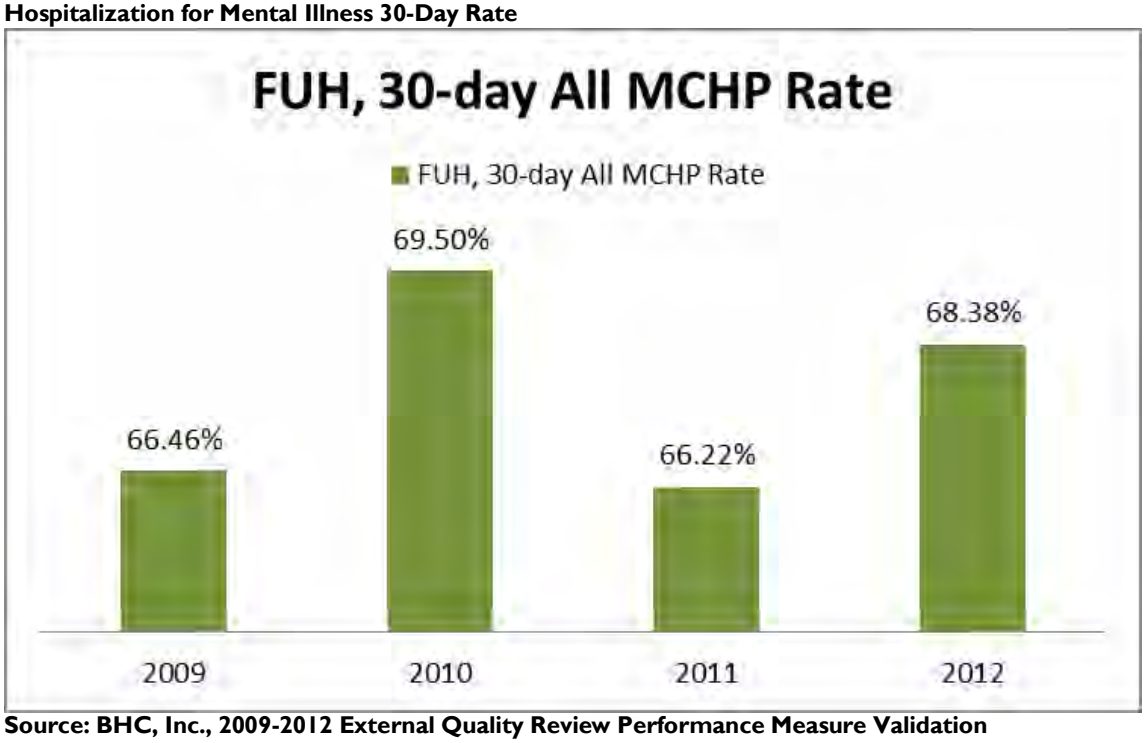
Figure 21 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness, 7-Day Rate



Source: BHC, Inc., 2009-2012 External Quality Review Performance Measure Validation

The Follow-Up After Hospitalization measure was previously audited by the EQRO in audit years 2006, 2007, 2009, 2010, and 2011, the analysis contained here will include 2009-2012 data (see Figure 22). The 30-Day reported rate for all MCHPs in 2012 (68.38%) was a 1.92% point increase overall since the rate reported in 2009 (66.46%), but was slightly lower than the rates reported in 2010 (69.50%).

Figure 22 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

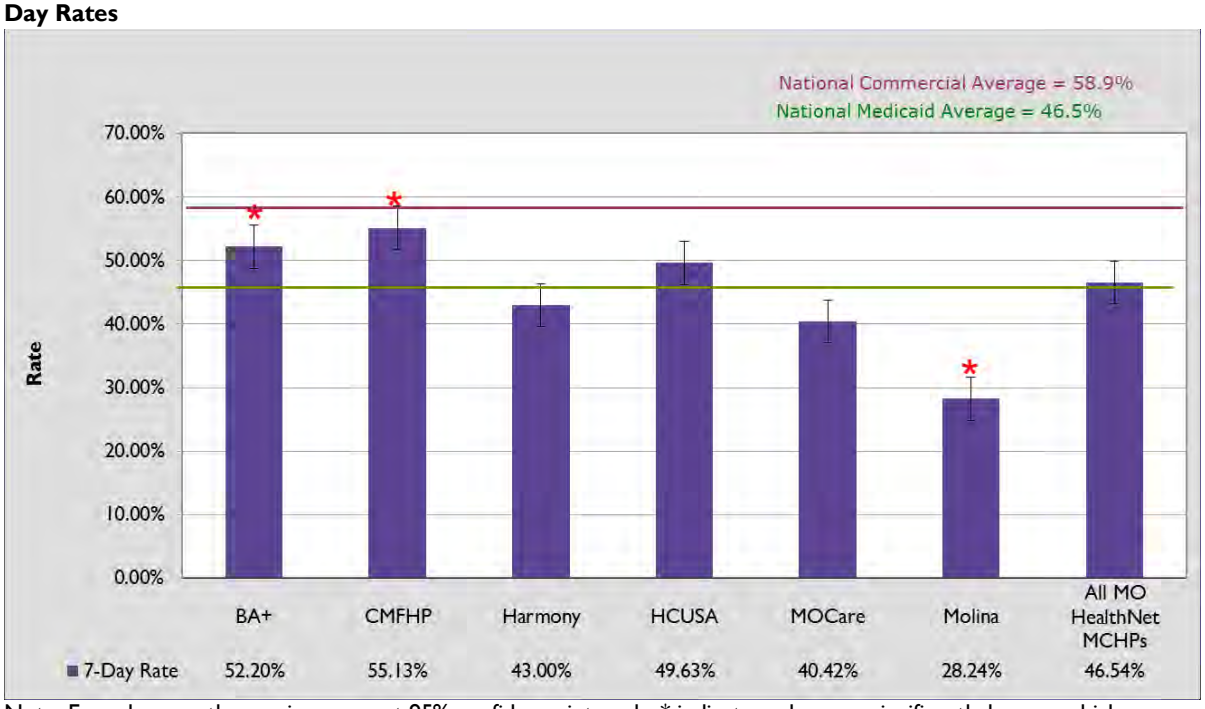


Source: BHC, Inc., 2009-2012 External Quality Review Performance Measure Validation

Figure 23 and Figure 24 illustrate the 7-Day and 30-Day rates reported by the MCHPs. The rate reported by each MCHP was compared with the rate for all MCHPs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MCHP with the rate for all MCHPs.

The 7-Day rates reported by Molina (28.24%) were significantly lower than the statewide rate (46.54%) for all MCHPs. BA+ (52.20%) and CMFHP (55.13%) reported rates significantly **higher** than the average. BA+, CMFHP, and HCUSA all reported rates **higher** than the National Medicaid Rate (46.5%), although all MCHPs were below the National Commercial Rate (58.9%).

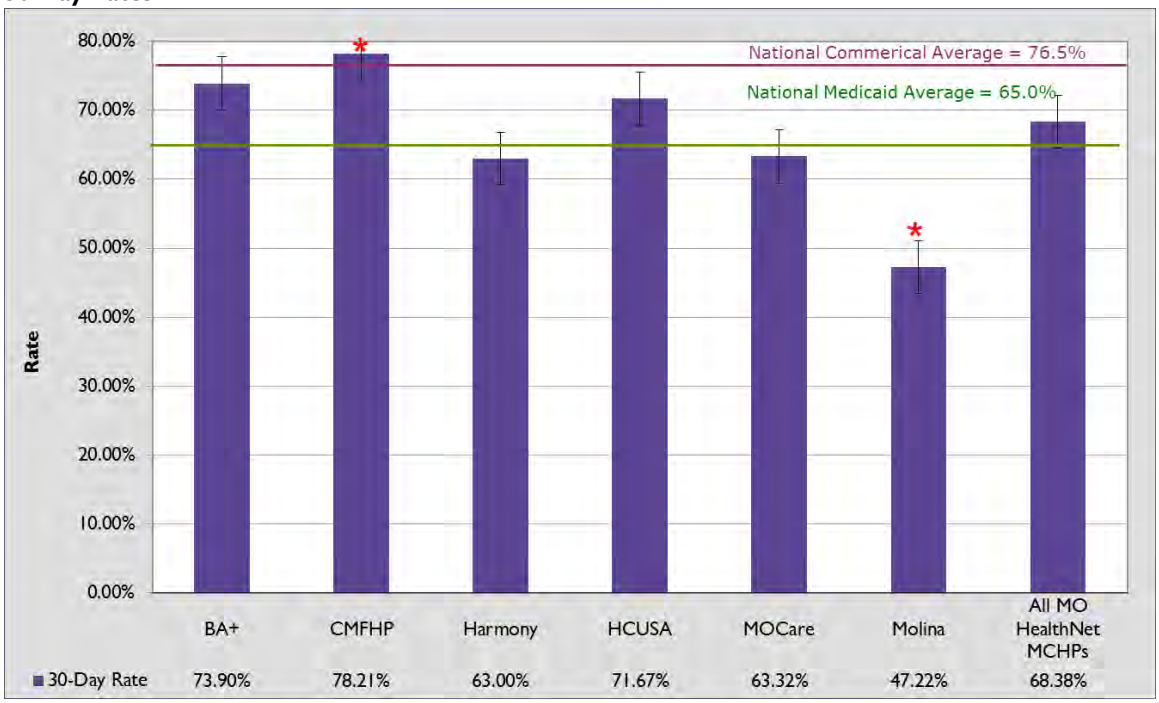
Figure 23 - Managed Care Program HEDIS 2012 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2012 DST; National Committee for Quality Assurance (NCQA).

The 30-Day rate reported for Molina (47.22%) was significantly lower than the statewide rate (68.38%) for all MCHPs. CMFHP was the only MCHP to report a rate higher than the National Commercial Average (76.5%). BA+, CMFHP, and HCUSA reported rates above the National Medicaid Rate of 65.0%.

Figure 24 - Managed Care Program HEDIS 2012 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



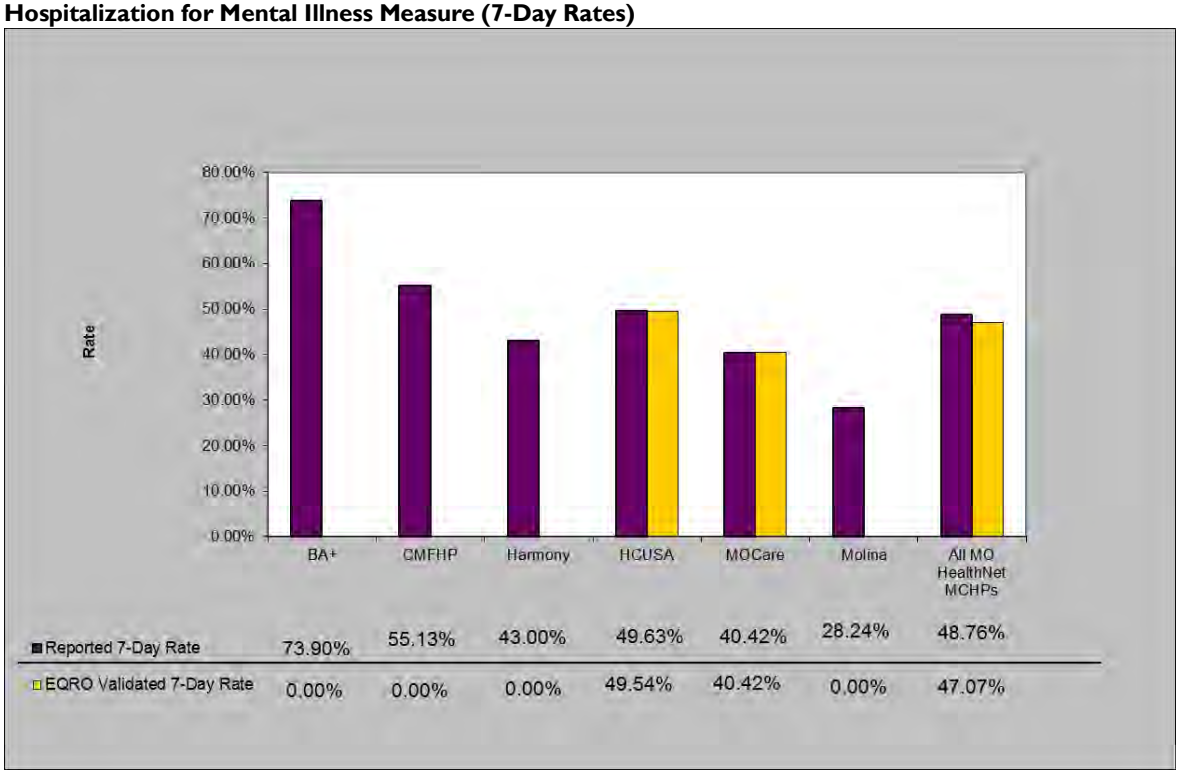
Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MCHP HEDIS 2012 DST; National Committee for Quality Assurance (NCQA)

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure. All MCHPs calculated and submitted the measure to the SPHA and SMA.

The 7-Day rates reported by MCHPs ranged from 28.24% (Molina) to 73.90% (BA+). The rate of all MCHPs calculated based on data validated by the EQRO was 47.07%. The MCHPs reported an overall rate of 48.76%, which is a 0.69% overestimate of the rates that could be fully validated (see Figure 25).

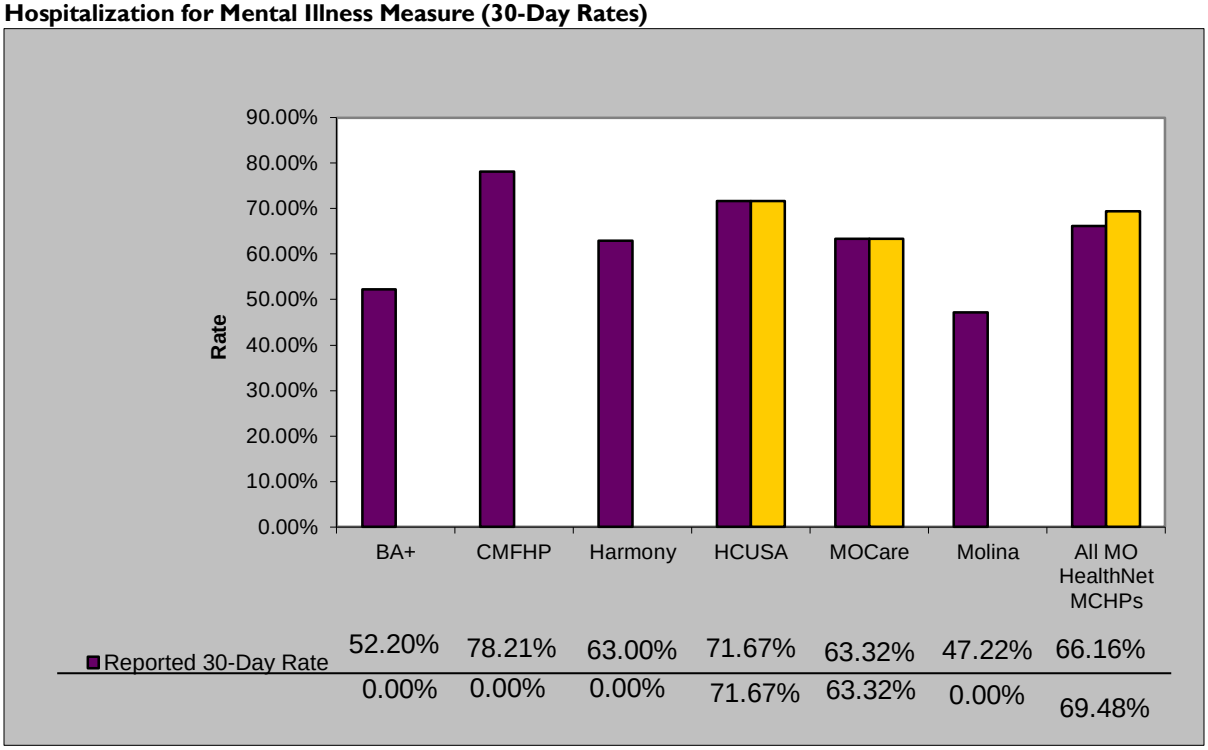
Figure 25 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure (7-Day Rates)



Sources: MCHP HEDIS 2012 Data Submission Tool (DST); BHC, Inc. 2012 External Quality Review Performance Measure Validation.

The 30-Day rate reported by MCHPs ranged from 47.22% (Molina) to 78.21% (CMFHP). The rate of all MCHPs calculated based on data validated by the EQRO was 69.48%. The rate reported by MCHPs was 66.16% (see Figure 26). The two MCHPs that continue to contract with the State of Missouri collectively produced an average rate higher than that of the four MCHPs no longer under contract with MO HealthNet.

Figure 26 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure (30-Day Rates)



Sources: MCHP HEDIS 2012 Data Submission Tool (DST); BHC, Inc. 2012 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 11, Table 12, and Table 13 provide summaries of ratings across all Protocol Attachments for each MCHP and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 100% for Annual Dental Visits; 100% for Childhood Immunizations Combo 3; and 98.28% for Follow-Up After Hospitalization for Mental Illness.

Table 11 - Summary of Attachment Ratings, HEDIS 2012 Annual Dental Visit Measure

	All MCHPs		All MCHPs
All Audit Elements	HCUSA	MOCare	
Number Met	30	30	***60***
Number Partially Met	0	0	***0***
Number Not Met	0	0	***0***
Number Applicable	30	30	***160***
Rate Met	100%	100%	***100.0%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2012 EQR Performance Measure Validation

Table 12 - Summary of Attachment Ratings, HEDIS 2012 Childhood Immunizations Status Measure

	All MCHPs		All MCHPs
All Audit Elements	HCUSA	MOCare	
Number Met	48	48	***96***
Number Partially Met	0	0	***0***
Number Not Met	0	0	***0***
Number Applicable	48	48	***96***
Rate Met	100%	100%	***100.0%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2012 EQR Performance Measure Validation

Table 13 - Summary of Attachment Ratings, HEDIS 2012 Follow-Up After Hospitalization for Mental Illness Measure

All Audit Elements	All MCHPs HCUSA	All MCHPs MOCare	All MCHPs
Number Met	28	29	***57***
Number Partially Met	1	0	***1***
Number Not Met	0	0	***0***
Number Applicable	29	29	***58***
Rate Met	96.55%	100%	***98.28%***

Note: Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2012 EQR Performance Measure Validation

Table 14 summarizes the final audit ratings for each of the performance measures by MCHPs. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MCHP extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MCHPs on the DST.

Table 14 - Summary of EQRO Final Audit Ratings, HEDIS 2012 Performance Measures

MCHP	Annual Dental Visit	Childhood Immunization Status Combo 3	Follow-Up After Hospitalization for Mental Illness (7 day)	Follow-Up After Hospitalization for Mental Illness (30 day)
Healthcare USA	Fully Compliant	Fully Compliant	Substantially Compliant	Fully Compliant
Missouri Care	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Source: BHC, Inc. 2012 EQR Performance Measure Validation

MO Care was found to be Fully Compliant in the calculation of all the measures, whereas HCUSA was Fully Compliant for the 30-day Follow-Up After Hospitalization for Mental Illness rate, Annual Dental Visit rate and the Childhood Immunization rate, but found to be Substantially Compliant in the calculation of the 7-day Follow-Up After Hospitalization for Mental Illness rate.

HEALTH PLAN INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

For the 2012 review, Behavioral Health Concepts, Inc. conducted an ISCA for each MCHP through electronic surveys, document review, and onsite interviews with the MCHPs and their contracted provider agencies. As a group, the MCHPs fully met the CMS standards for hardware systems, integrating vendor Medicaid data, and CMS standards in other areas.

The following highlights the strengths and opportunities for improvement for MCHPs in each section of the ISCA review.

Data Processing Procedures and Personnel - Strengths

Infrastructure

All three (3) MCHPs or their third-party administrator (TPA) employed robust mid-range machines for processing data.

Programming/Report Development

Among MCHPs that maintained in-house database systems, including commercial systems, each incorporated quality assurance processes for application development and software upgrades.

Security

All MCHPs had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access.

The majority of the MCHPs' contracted providers submitted encounter data electronically in encrypted and/or password-protected files each month.

All MCHPs that maintained in-house database systems had good maintenance contracts in place for hardware and software to ensure timely support.

Data Acquisition Capabilities - Strengths

Encounter data

All MCHPs could track the history of enrollees with multiple enrollment dates and whether enrollees were dually enrolled in Medicare and Medicaid.

All MCHPs or their TPA had formal documentation for processing claims and encounter data. The majority of MCHPs or their TPA had instituted multiple checkpoints for validation of encounter data.

Auditing

All MCHPs or their TPA had a documented process for training claims and billing personnel, which included auditing the performance of new employees to ensure accuracy.

Staffing

This section of the protocol applies to the MCHP or TPA staff assigned to process encounter and claims data. A "Fully Met" score reflects adequate numbers of trained staff for processing accurate, complete, and timely encounter data; a comprehensive, documented training process for new hires and seasoned employees; established and monitored productivity goals for data processing; and low staff turnover. All of the MCHPs fully met these criteria.

Hardware Systems

Quality and maintenance of computer equipment and software are important in ensuring the integrity and timeliness of encounter data submitted to the state. Desirable features include robust server equipment; hardware redundancy in terms of data storage devices and other key components; premium hardware maintenance contracts; software maintenance contracts for commercial database systems; and a standby server as a backup to the main production server. All of the MCHPs fully met these criteria.

Security of Data Processing

Behavioral Health Concepts, Inc. evaluated the physical security of each MCHP's data as well as the MCHP's backup systems and methods for protecting the database from corruption.

All MCHPs substantially met requirements. Each MCHP provided good physical security, a documented security policy, good internal controls, and an effective batching procedure. A secure offsite storage facility is used to store backup tapes; backup tapes are encrypted and transported in compliance with HIPAA.

3.3 Conclusions

In calculating the measures, all of the MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2012 measures validated.

Among MCHPs there was good documentation of the HEDIS 2012 rate production process. The rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was excellent, with the EQRO receiving all of the medical records requested. This review also marked the second review year in which all contracted MCHPs performed a hybrid review of the measure selected, allowing for a complete Statewide comparison of those rates.

QUALITY OF CARE

The HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by MCHP members.

Of the two MCHPs that were fully validated by the EQRO, one was Fully Compliant with the specifications for calculation of this measure and the other MCHP was substantially compliant with the specifications for calculation of this measure.

Although the rates could not be validated for all six MCHPs that delivered services to Managed Care members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

For the 7-day follow up rate, three MCHPs (BA+, CMFHP and HCUSA) reported rates (52.20%, 55.13% and 49.63%, respectively) that were higher than the National Medicaid Average (46.5%) for this measure. The statewide rate for all MCHPs (46.54%) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2009, 2010 and 2011. The 7-Day reported rate for all MCHPs in 2012 (46.54%) continues a steadily increasing trend, as access to follow-up services after hospitalizaton for mental illness continues to improve for MOHealthNet Managed Care recipients in Missouri.

For the 30-day follow up rate, three MCHPs (BA+, CMFHP, and HCUSA) all reported rates (73.90%, 78.21% and 71.67% respectively) that were above than the National Medicaid Average (65.0%) for this measure. The overall MCHP rate (68.38%) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2009, 2010, and 2011. The 30-Day reported rate for all MCHPs in 2012 (68.38%) was an increase from the 2011 rate (66.22%), but was a decrease from the rate reported in 2010 (69.50%). However, the overall rate still remains higher than the rate reported in 2009 (66.46%).

From examination of these rates, it can be concluded that MCHP members are receiving a quality of care comparable to or higher than other Medicaid participants across the country within the 30-day timeframe in the area of Follow-Up After Hospitalization for Mental Illness, but the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, based on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes.

Access to Care

The HEDIS 2012 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure.

Although the rates could not be validated for all six MCHPs that delivered services to Managed Care members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

The Annual Dental Visits measure has been audited in the 2009, 2010, 2011, and 2012 external quality reviews. Over the course of these review periods, the rates for all MCHPs have

improved steadily. In 2012, two MCHPs reported rates higher than the National Medicaid Average of 45.8%, these MCHPs are CMFHP (50.17%) and HCUSA (46.29%).

This trend shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2012 measurement year.

TIMELINESS OF CARE

The HEDIS 2012 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

Of the two MCHPs that were fully validated by the EQRO, both were Fully Compliant with the specifications for calculation of this measure.

Although the rates could not be validated for all six plans that delivered services to MO HealthNet members during the HEDIS 2012 review year, those rates are being compared to show a true statewide picture of service delivery during that year.

Although Combination 3 for this measure was audited in 2011, not enough data exists for trend analysis. However, the statewide rate reported for Childhood Immunizations Status, Combination 3 measure in 2012 (61.27%) was **higher** than the rate reported in 2011 (57.47%). None of the MCHPs reported a rate in 2012 higher than the National Medicaid Average of 70.6% or the National Commercial Average of 75.7%.

This illustrates a timeliness of care for immunizations delivered to children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

RECOMMENDATIONS

1. The SMA should continue to encourage the use of the Hybrid Method of calculation for HEDIS measures that allow these reviews. The Hybrid review process produces higher rates on average than an Administrative method alone.
2. MCHPs with significantly lower rates of eligible members for Annual Dental Visit (MO Care), Childhood Immunizations Status (MO Care) and Follow-Up After Hospitalization for Mental Illness (MO Care) should closely examine the potential reasons for fewer members identified.
3. MCHPs with significantly lower administrative hits [Follow-Up After Hospitalization for Mental Illness (MO Care)] should closely examine the potential reasons for fewer services identified. This may be due to member characteristics, but is more likely due to administrative procedures and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.
4. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
5. MCHPs should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be employed.

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4.0 MO HealthNet MCHP COMPLIANCE WITH MANAGED CARE REGULATIONS

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4.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E." The EQRO uses the Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements during the review process, with an emphasis on areas where individual MCHPs have previously failed to comply or were partially compliant at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MO HealthNet MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet Managed Care contract requirements; and with the progress made in achieving quality, access, and timeliness to services from the previous review year.

This year's review (calendar year 2012) is a full compliance review, follow-up reviews will be conducted for 2013 and 2014. The SMA reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Case Management processes. The review included case record reviews and interviews with Case Management and Administrative staff. The results of the Case Management review will be reported in detail in another section of this report as a "Special Project". The interview tools used were based on information obtained from each MCHPs' 2012 Annual Report to the SMA and the SMA's Quality Strategy.

Obtaining Background Information from the State Medicaid Agency

Interviews and meetings occurred with individuals from the SMA from February 2013 through June 2013 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits.

In February 2013, Compliance Review team members began discussions with the SMA to determine the direction and scope of the review. The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the Managed Care MCHPs' (MCHP) compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special

project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

Document Review

Documents chosen for review were those that best demonstrated each MCHP's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks were reviewed to ensure that consistent information was shared regarding enrollee rights and responsibilities. Managed Care contract compliance worksheets and case management policies were reviewed as a basis for interview questions that made up the main focus of the 2012 Compliance Review. Other information, such as the Annual Quality Assessment and Improvement Evaluation was requested and reviewed to provide insight into each MCHPs' compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the Managed Care contract, and is required by the federal regulations. MCHPs' Quality Improvement Committee meetings minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in discussions with MCHP staff. In addition, interviews based on questions from the SMA and specific to each MCHP's Quality Improvement Evaluation, were conducted with administrative staff to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it was found that specific regulations were "Partially Met," additional documents were requested of each MCHP. Interviews with Administrative staff occurred to address the areas for which compliance was not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MCHPs:

- State contract compliance ratings from 2012 and updated policies accepted through June 2013
- Results, findings, and follow-up information from the 2011 External Quality Review
- 2012 MCHP Annual Quality Assessment and Improvement Evaluation

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2012 Compliance Review would include interviews with Case Management Staff (under the guidelines of the "Special Project") and Administrative Staff. The goal of these interviews was to validate that practices at the MCHPs, particularly those directly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures. After completing the initial document review, it was clear that the MCHPs had made significant progress in developing appropriate and compliant written policies and procedures. The interview questions were developed using the guidelines available in the Compliance Protocol and focused on areas of concern based on each MCHP's adherence to their policy. Specific questions were also posed, using examples from the records reviewed. Corrective action taken by the two MCHPs previously under contract with the State of Missouri was determined from the previous years' reviews. This process revealed a wealth of information about the approach each MCHP took to become compliant with federal regulations.

The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. A site visit questionnaire specific to each MCHP was developed. The questions were developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

ANALYZING AND COMPILING FINDINGS

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

Reporting to the State Medicaid Agency

Discussion occurred with the SMA staff to ensure that the most accurate information was recorded and to confirm that a sound rationale was used in rating determinations. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. The actual ratings are included in this report.

Compliance Ratings

The EQRO continues to utilize a Compliance Rating System that was developed during previous reviews. This system was based on a three-point scale ("Met," Partially Met," "Not Met") for measuring compliance, as determined by the EQRO analytic process. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses that validate MCHP practices observed on-site.

If the SMA considered the policy submission valid and rated it as complete, this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained in the narrative included in the individual MCHPs Compliance Section. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MO HealthNet MCHP staff was able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MCHP was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

4.2 Findings

ENROLLEE RIGHTS AND PROTECTIONS

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of heath plans for the provision of information to enrollees in an understandable form and language: written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. Across all MCHPs 100% of the regulations were rated as "Met", this is higher than the 2011 review year when 83.3% of the regulations were rated as "Met". During the 2010 review year all MCHPs were 100% complaint with these standards and during the 2009 review the All MCHP rate of "Met" was 94.87%.

All MCHPs had procedures in place to ensure that members: receive pertinent and approved information [438.100(a) and 438.10(b)]; were addressed in their prevalent language [438.10(c)(3)]; have access to required interpreter services [438.10(c)(4,5)]; that all information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2)]; that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and that the MCHPs are in compliance with other state requirements [438.100(d)]. All MCHP's were also found to have practices that met these requirements.

One of the MCHPs (HCUSA) continues to utilize a Member Advisory Committee that serves to provide insight into the issues faced by members who are attempting to obtain healthcare services. This MCHP incorporated member suggestions into their operations and marketing materials. These activities were indicators of the MCHP's commitment to member services and to ensuring that members have quality healthcare.

All MCHPs continued to operate programs for the provision of behavioral health services. Two of the MCHPs subcontract with Behavioral Health Organizations (BHO) for these services, however, both subcontracted entities are part of each MCHPs corporate organization. One MCHP (MO Care) utilizes an "in-house" model for the provision of behavioral health services. MO Care uses a system of integrated case management and maintenance of the provider delivery system within their MCHP structure.

Compliance Interviews

Interviews were held at each MCHP with case management and administrative staff to obtain clarification on issues identified from the policy and document reviews, and to clarify some responses received from the case managers. Interview questions were developed from the review of each MCHP's case management policy and from the case records reviewed prior to the time of the on-site review. These interview questions were specific to each MCHP, and focused on issues that might compromise compliance with required case management activities. The specific findings of these interviews are reported in the "Special Project" section of this report.

Quality Assessment and Performance Improvement: Access Standards

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists; the ability to access out-of-network services in certain circumstances; adequate care coordination for enrollees with special healthcare needs; development of a method for authorization of services, within prescribed timeframes; and the ability to access emergency and post-stabilization services. There were 4 regulations rated as "Not Met" for the 2012 review. However, across all MCHPs, the rate of regulations that were "Met" for the 2012 review (83.67%) has improved from the 2011 rate of 75.49%, but is a **decrease** from the 2009 rate of 86.7%. Two of the MCHPs (HCUSA and MO Care) were found to be 88.24% compliant; while the remaining MCHP (Home State) was 64.71% compliant.

- Both HCUSA and MO Care improved over their 2011 rates of 76.5% and 82.35% respectively.
- This is the first year of operation for Home State and a lower rating is to be expected when a MCHP is beginning operation.

The rating for the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project (this is discussed in greater detail in Section 5 of this report).

All MCHPs had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Other areas where all MCHPs were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural

Competency; Timeframes for Decisions for Expedited Authorizations; and Emergency and Post-Stabilization Services. Throughout this review period, all MCHPs reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the MCHPs excelled.

Table 15 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

	MCHP			All MO HealthNet MCHPs			
Federal Regulation	HCUSA	Home State	MO Care	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2	3	0	0	100.0%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2	3	0	0	100.0%
438.206(b)(3) Second Opinions	2	2	2	3	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	3	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	3	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	1	2	2	1	0	66.7%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	3	0	0	100.0%
438.208(b) Care Coordination: Primary Care	1	0	1	0	2	1	0.0%
438.208(c)(1) Care Coordination: Identification	2	0	2	2	0	0	100.0%
438.208(c)(2) Care Coordination: Assessment	2	0	2	2	0	0	100.0%
438.208(c)(3) Care Coordination: Treatment Plans	1	0	1	0	2	1	0.0%
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2	3	0	0	100.0%
438.210(b) Authorization of Services	2	1	2	2	1	0	66.7%
438.210(c) Notice of Adverse Action	2	2	2	3	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	3	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	2	2	3	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	3	0	0	100.0%
Number Met	15	11	15	41	6	2	83.67%
Number Partially Met	2	2	2				
Number Not Met	0	4	0				
Rate Met	88.24%	64.71%	88.24%				

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2012). Assessment of Compliance with Medicaid Managed Care Regulations, Protocol 1, v. 2.0, September 1, 2012; BHC, Inc., 2012 External Quality Review Monitoring MCHPs Protocols.

Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in the interviews. Required documentation and approved policies did exist in all areas for all MCHPs.

All of the MCHPs had complete policy and Provider Manual language in the area of emergency and post-stabilization services [438.114]. The MCHPs made efforts to ensure that the problems

they experienced did not affect services to members. All MCHPs provided evidence of strong relationships with their providers and maintained strong communication with them particularly in solving member service problems.

Quality Assessment and Performance Improvement: Structure and Operation Standards

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, grievance systems, and accountability for activities delegated to subcontractors. Across all MCHPs 100% of the regulations were rated as "Met", this is an improvement over the 2011 rating of 84.31% , and is consistent with the 2010 review year when all MCHPs were 100% compliant with these standards.

It was evident that the Provider Services departments of the MCHP exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and Managed Care requirements. All of the MCHPs were 100% compliant with these regulations. This included Provider Selection [438.214(d) and 438.214(e)]; Timeframes [438.56(e)]; and disenrollment. The staff interviewed at each MCHP understood the requirements for disenrollment. All of the MCHPs described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All MCHPs have developed policy and procedures that comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MCHPs and other commercial networks. All of the MCHPs (100.0%) had all required policies and practices in place regarding credentialing.

Quality Assessment and Performance Improvement: Measurement and Improvement

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of PIPs; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. A total of 93.8% of the criteria were "Met" by MCHPs, this is an increase over the 2011 review year, when 81.82% of the criteria were "Met" by all MCHPs. This is consistent with the

93.9% rate in 2010 and the 2009 rate of 92.4%.

Only one MCHP (HCUSA) met all the requirements (100%) in this area. The two remaining MCHPs received a rating of 90.90% in this area, each of these MCHPs had one "Partially Met" rating. The areas that were Partially Met were difficulty with the Performance Improvement Project process.

Table 16 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP			All MO HealthNet MCHPs			
	HCUSA	Home State	MOCare	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	3	0	0	100.0%
438.236(c) Practice Guidelines: Dissemination	2	2	2	3	0	0	100.0%
438.236(d) Practice Guidelines: Application	2	2	2	3	0	0	100.0%
438.240(a)(1) QAPI: General Rules	2	2	2	3	0	0	100.0%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	1	1	2	0	33.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	NA	2	2	0	0	100.0%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	3	0	0	100.0%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	3	0	0	100.0%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	3	0	0	100.0%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	3	0	0	100.0%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	3	0	0	100.0%
Number Met	11	9	10	30	2	0	93.8%
Number Partially Met	0	1	1				
Number Not Met	0	0	0				
Rate Met	100.0%	90.0%	90.91%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet Managed Care Program.
0 = Not Met; 1= Partially Met ; 2 = Met
Sources: BHC, Inc., 2012 External Quality Review Monitoring MCHPs Protocols.

During the on-site reviews it was evident to the reviewers that practice guidelines have become a normal part of each MCHPs' daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All of the MCHPs met all the requirements for adopting, disseminating and applying practice guidelines.

All MCHPs (100.0%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MCHPs reported using included the InterQual Clinical Decision Support Tool, LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. The MCHP staff was able to articulate how they utilized these tools and apply them to member healthcare management issues.

GRIEVANCE SYSTEMS

Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers and subcontractors regarding grievance and appeal procedures and timelines available to enrollees and providers. All three MCHPs were found to 100% compliant with the Grievance Systems requirements.

4.3 Conclusions

Across all MCHPs there continues to be a commitment to improving and maintaining compliance with federal regulations. There are only a few regulations rated as "Not Met." All other individual regulations were rated as "Met" or "Partially Met." All MCHPs were 100% compliant with three of the compliance areas validated during this review year.

For the third year in a row, none of the MCHPs were 100% compliant with all requirements. This is attributable to the in-depth review of the MCHPs' Performance Improvement Projects and the Case Management Special Project review. All MCHPs were unable to demonstrate case management information that fully exhibited compliance with the aspects care coordination.

All of the MCHPs exhibit attention to becoming and remaining compliant with the SMA contractual requirements and the corresponding federal regulations. All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this

documentation and interview responses. Both of the experienced MCHPs made it clear that they used the results of the prior EQR to complete and guide required changes, this was evident in many of the areas that the EQRO noted improvement. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

QUALITY OF CARE

The 13 regulations for Enrollee Rights and Protections were 100% "Met" by all MCHPs. Communicating Managed Care members' rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all MCHPs. These MCHPs were aware of their need to provide quality services to members in a timely and effective manner.

The 10 regulations for Structure and Operations Standards were 100% "Met" by all MCHPs. These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the third year in a row that all of the MCHPs maintained a 100% rating in this set of regulations. These MCHPs articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their Managed Care members.

ACCESS TO CARE

The two MCHPs that have been previously audited by the EQRO **improved** in their compliance with the 17 federal regulations concerning Access Standards during this year's review. These two MCHPs were 88.24% compliant. The remaining MCHP (Home State) was found to be 64.71% compliant with these standards.

The EQRO observed that most of the MCHPs had case management services in place. The case management records requested did not always contain information to substantiate these onsite observations.

Each MCHP described measures they used to identify and provide services to MO HealthNet Managed Care members who have special healthcare needs. All of the MCHPs could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other

specialist service providers that might be required. The MCHPs were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members. One area of concern is care coordination. Although all MCHPs had all required policy in place, none of them were able to demonstrate through chart review that they had fully compliant care coordination processes in place.

Timeliness of Care

This is a much improved area of compliance for all the MCHPs. Ten of the eleven regulations for Measurement and Improvement were 100% "Met." However, only one of the three MCHPs met all of the regulatory requirements. All of the MCHPs adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. These MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.

The MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs. This was not always evident in the documentation reviewed. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of members. The MCHPs all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

All of the regulations for Grievance Systems were 100% "Met" for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs.

The MCHPs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and

occasionally experimental treatment options, which would not otherwise be available to members. The MCHPs observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

1. MCHPs should continue to submit all required policy and procedures in a timely manner. This is only the second review year when all MCHPs have approved policy and procedures. This improvement is likely due to the requirement that all MCHPs be NCQA accredited.
2. All MCHPs need to examine their case management programs. Attention to the depth and quality of case management services should be a priority for every MCHP. Goals should be established for the number of members in case management and the outcomes of the delivery of case management services. Continued attention must be applied to ensure the EQRO receives documentation as requested to validate that these services are occurring.
3. It is not enough to have the written policies in place in regards to case management, each MCHP must ensure that the practice of all case managers meets and exceeds those written policies.
4. Efforts must be made to inform provider offices of all members enrolled in case management. Relationships should be fostered between case management staff and the provider office staff, this could go a long way to ensure valid contact information can be obtained for members and to ensure that members in case management are receiving all the services they require by establishing a healthcare home.
5. Efforts must be made to outreach to community based agencies that serve these members, these agencies can often provide contact information for members.

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5.0 MO HealthNet MCHP SPECIAL PROJECT CASE MANAGEMENT PERFORMANCE REVIEW

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5.1 Purpose and Objectives

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the case management programs for all three Managed Care MCHPs' (MCHP). The EQRO was to assess the MPHCs' compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services.

The objectives of this special project are to complete:

1. An in-depth follow-up review of Case Management by assessing if the MCHPs' made improvement in service delivery and record keeping; and
2. To evaluate the MCHP's compliance with the federal regulations and Managed Care contract as it pertains to Case Management.

The steps taken in this review included:

- Assessing the MCHPs' attention and performance in providing case management to:
    a. Pregnant members;
    b. Members with special health care needs; and
    c. Children with elevated blood lead levels;
- Assessing the MCHP's response to referrals that result from members who frequent the Emergency Room as a source of primary care (this part of the case management review did not include Home State Health Plan, as they began operations in July 2012);
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases they report as open in their system.

METHODOLOGY

The review included the following components:

1. Review of each MCHP's case management policy and procedures;
2. Case record reviews of thirty (30) cases. These case listings were received from the MCHPs and included open and active cases sorted by category: lead; pregnant women/OB; and special healthcare needs. (These cases were open in the fourth quarter of 2012);
3. Case record reviews of ten (10) cases from HCUSA and MO Care that resulted in case

management after the member visited the Emergency Department. These listings included the names of all members who had three (3) or more Emergency Department visits in the second and third quarters of 2012 (excluding Home State as they did not begin operations until the third quarter of 2012); and

4. On-site interviews with case management staff and MCHP administrative staff.

The MHD Managed Care staff reviews and approves all MCHP policy. Questions developed by the EQRO in the case record review process focused on compliance with the requirements of case management as set out in the Managed Care contract and as developed from the actual record review. Case review results reflected how well individual files met both the MCHP's policy requirements and those of the Managed Care contract.

The records were reviewed by EQRO Consultant Myrna Bruning, R.N. and EQRO Assistant Project Director, Mona Prater. A case review form, pre-approved by the SMA, was used to assess the quality of the medical case records received.

CASE RECORD REVIEWS

A listing of open and active cases from the fourth quarter of 2012 was requested from all three MCHPs, organized by type including lead, OB, and special health care needs. A random sample of ten (10) cases per category from the listings provided by each MCHP was requested for review. The MCHPs sent all requested case records to the EQRO. An additional ten (10) cases of Emergency Department referrals were requested from MO Care and HCUSA.

ON-SITE INTERVIEWS

The purpose of the on-site interviews was to:

- Evaluate the case managers' knowledge of the Managed Care contractual requirements of their position; and
- Determine methods used by case managers to operationalize policy in their daily activities.

The interviews occurred at each MCHP as follows:

1. Interviews were conducted during the on-site review. Interview questions were based on the Managed Care contract requirements and the outcomes of the record reviews. Each

interview tool addressed issues specific to the MCHP's review results and included general questions for each MCHP's staff.

2. Interviews were conducted with direct service staff at each MCHP. Each interviewee's presence was requested prior to the date of the on-site review. If staff was not available, substitutions were accepted.

Case Management Record Review

The case management record review was designed to verify that case management activities were conducted in compliance with the Managed Care contract and with all applicable federal policies. The results are divided into categories that summarize these reviews. A comparison with the results of the 2010 and 2011 case record review, for each category, is also part of this evaluation. The comparison results are not available for Home State as it was in its first six months of operations during 2012.

The case files were evaluated based on the Case Management requirements found in the July 1, 2012 Managed Care contract.

5.2 Findings

The findings include the results of the case management record review and on-site interviews for all three MCHPs. The charts in this section include the results of the case record reviews and the information obtained during the case manager interviews.

Case Record Review Results

Introduction to Case Management

There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

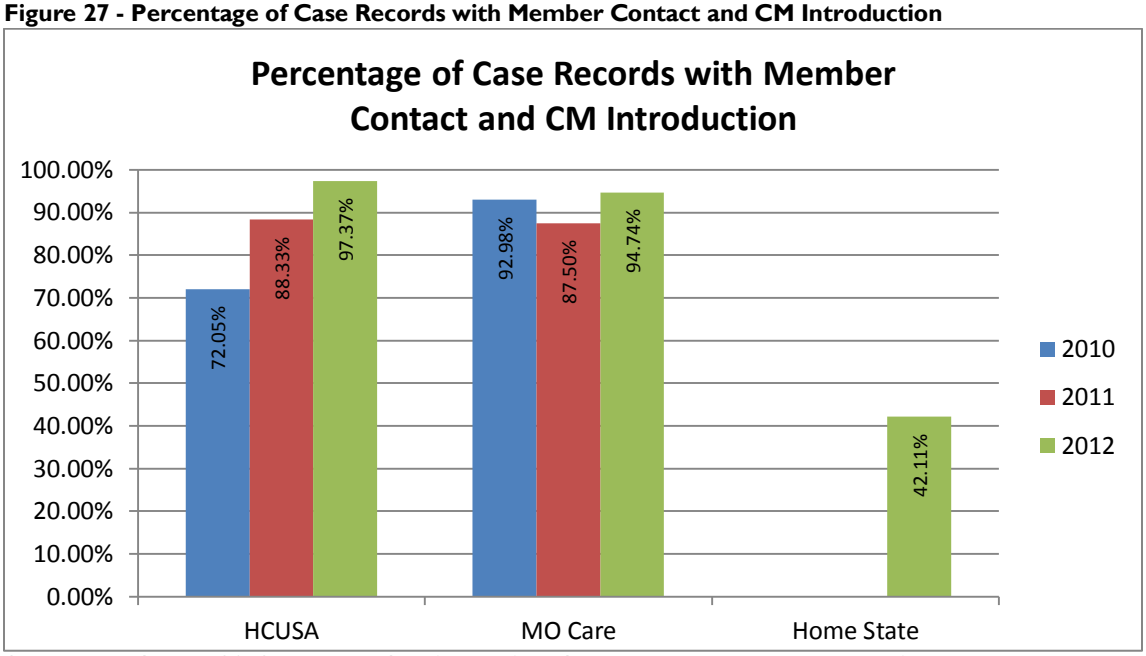
1. Identifying information used to locate and maintain contact with the member;

2. Case opening – after receipt of referral was a case opened for assessment and service delivery;

3. Introduction to Case Management –the case manager explained the case management process to the member; and

4. Acceptance of Services –the member indicated they agreed with the MCHP providing case management services.

Figure 27 - Percentage of Case Records with Member Contact and CM Introduction



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

The following information was obtained from the record review and on-site interviews:

- Obtaining referrals, locating members, introducing them to the case management process, and eliciting their acceptance of case management services are essential functions for case managers.

  - Both HCUSA and MO Care improved in this area. These MCHPs' percentages increased in all four standards from 2010 to 2012. This indicates that the efforts to contact members and explain the case management process were successful.

  - The newest MCHP (Home State) does not have previous experience, as they received a contract in July 2012. Their percentages indicate that they are contacting members. However, they are not always successfully engaging them into accepting case management. Cases reviewed for this MCHP during the 2012 EQR included:

    - Eleven (11) cases where there was no contact or where no explanation about case management was initiated.
      - One member they were unable to locate even after repeated and prolonged attempts;
      - One member initially accepted case management, but lost contact with the MCHP. The case manager did make more than the three required attempts to locate and work with this individual.
      - Nine (9) cases reflected at least two attempted telephone contacts and an

"Unable to Contact" letter to members, but no significant efforts to locate or engage the members into accepting services.

- In the remaining nineteen (19) reviewed:
  - Eight (8) included members initial contacts, case management explanation, and the members' acceptance of services.
  - Four (4) cases contained some of the information required, but the introduction was not complete.
  - Seven (7) included no introductory information.
- One member refused case management. Case notes indicate the member commented that she had completed three assessments, asking essentially the same questions, and that they did not have time for these questions and no services.
- One Special Health Care Needs member was originally listed as "high risk" diagnosed with Stage 4 cancer. After the assessment was complete the case was coded as "low risk" with no explanation. Shortly thereafter the case was closed due to the death of the member.
- EQR case reviewers identified instances where efforts to regain contact with members were limited. In these cases, the case manager did not explore alternative methods of contact, such as contact with provider offices to request current demographic information.

- Case managers receive referrals from a variety of sources internal and external to the MCHP.

  - Members have the option of declining case management services. In most records reviewed for HCUSA and MO Care, when members were contacted they welcomed the support that case management offers, thereby in the majority of instances case management services were accepted.

- Case managers are required to explain the nature of the case management relationship, the contact they will have with the member and the services available. Case managers must request approval to discuss the case with a third party, if appropriate, discuss the availability of a complaint process, and explain any contacts with the providers involved.

  - This activity occurred in most cases that were opened and was reflected in the case record information, along with the member's agreement to accept services.

- Cases that were referred to Home State due to Elevated Blood Lead Levels (EBLL) indicated little or no member contact.

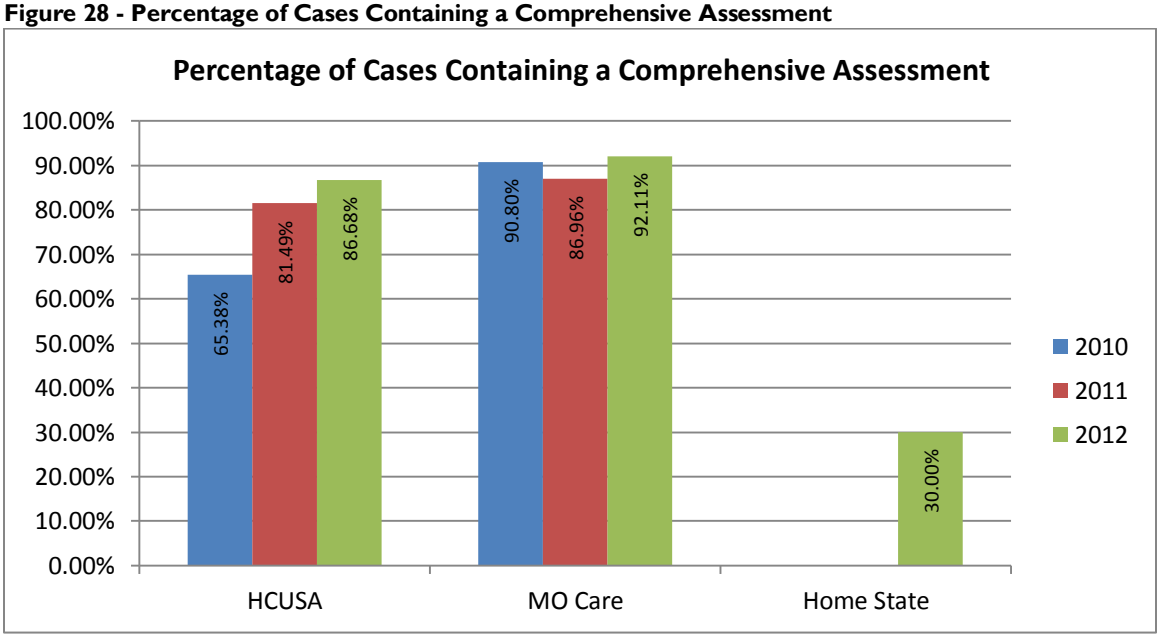
  - These cases were closed in the MCHP's system in violation of contract terms, and the case manager did not follow or track these cases to ensure that the member's blood level returned to and maintained normal levels.

ASSESSMENT

The standards used to evaluate the assessment of the member's service needs include:

1. Completion of assessment within specified time frames; and
2. Inclusion of a comprehensive assessment in the file.

Figure 28 - Percentage of Cases Containing a Comprehensive Assessment



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

- All records/or progress notes must include an assessment tool, questions, and member response.
  - In HCUSA and MO Care records the assessment tool or questions were found in more case records in 2012 than in previous years.
  - The records from Home State did provide assessment information in thirty percent of their records. The inclusion of the assessment tool, or narrative comments regarding assessment results was sporadic and lacked consistency across all service types.
- These assessments are to be comprehensive in nature for all MCHPs. This requirement did improve in 2012.

- In the cases that included assessment tools, standardized questions were asked of all members. Notes were often included in HCUSA and MO Care cases indicating that the case manager evaluated the answers and utilized this information in the work with the member. This was not found in past reviews.

- In Home State cases, a brief Health Risk Assessment could be found in eighteen (18) cases. During the on-site interviews case managers explained that this form is used by the intake staff to evaluate if the member is a candidate for case management services. If the member qualifies for case management the intake staff uses the Health Risk Assessment to assign potential risk. The actual comprehensive case management assessment was only available in nine (9) of the records reviewed.

- There continues to be a disconnect between members indicating a need for behavioral health services, or even admitting that they had behavioral health issues during the assessment, and follow through with referrals to a behavioral health provider. It should be noted that MO Care provides a coordinated system of services and an integrated approach to ensuring referrals between physical health and behavioral health.

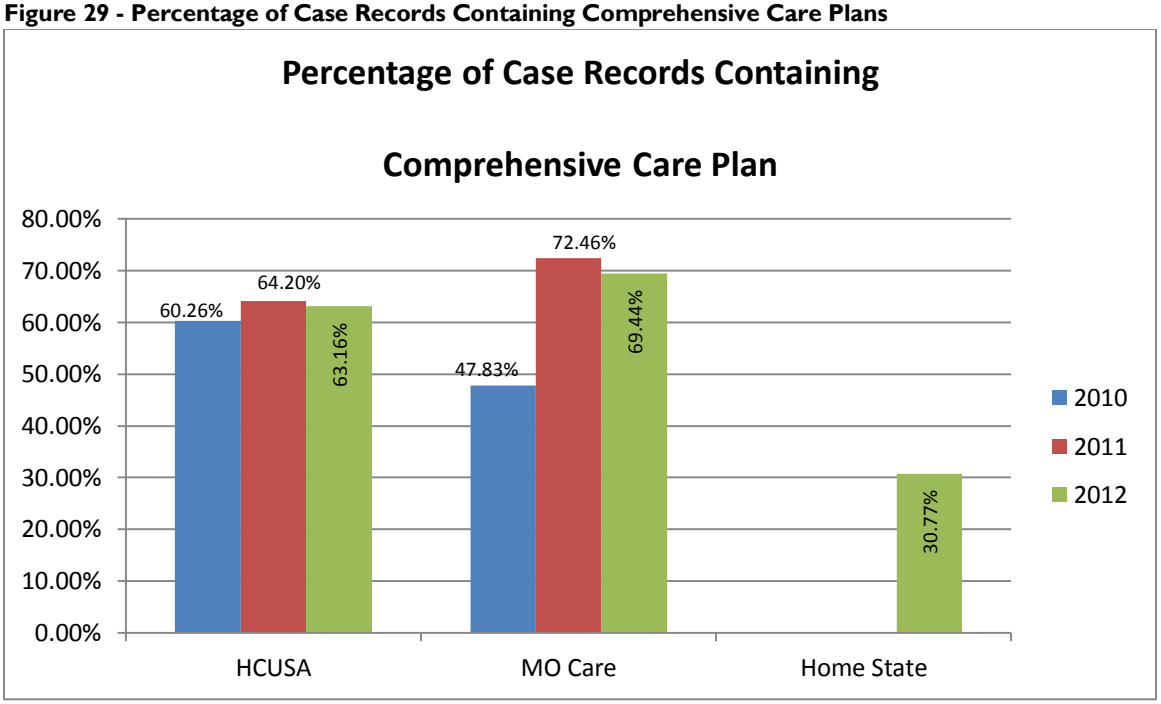
CARE PLANNING

The standards used to evaluate appropriate care planning require:

1. A care plan; and

2. A process to ensure that the primary care provider, member or their primary care giver (parent or guardian), and any specialists treating the member are involved in the development of the care plan.

Figure 29 - Percentage of Case Records Containing Comprehensive Care Plans



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

Both HCUSA and MO Care show a slight decrease in compliance with the inclusion of care plans in each case.

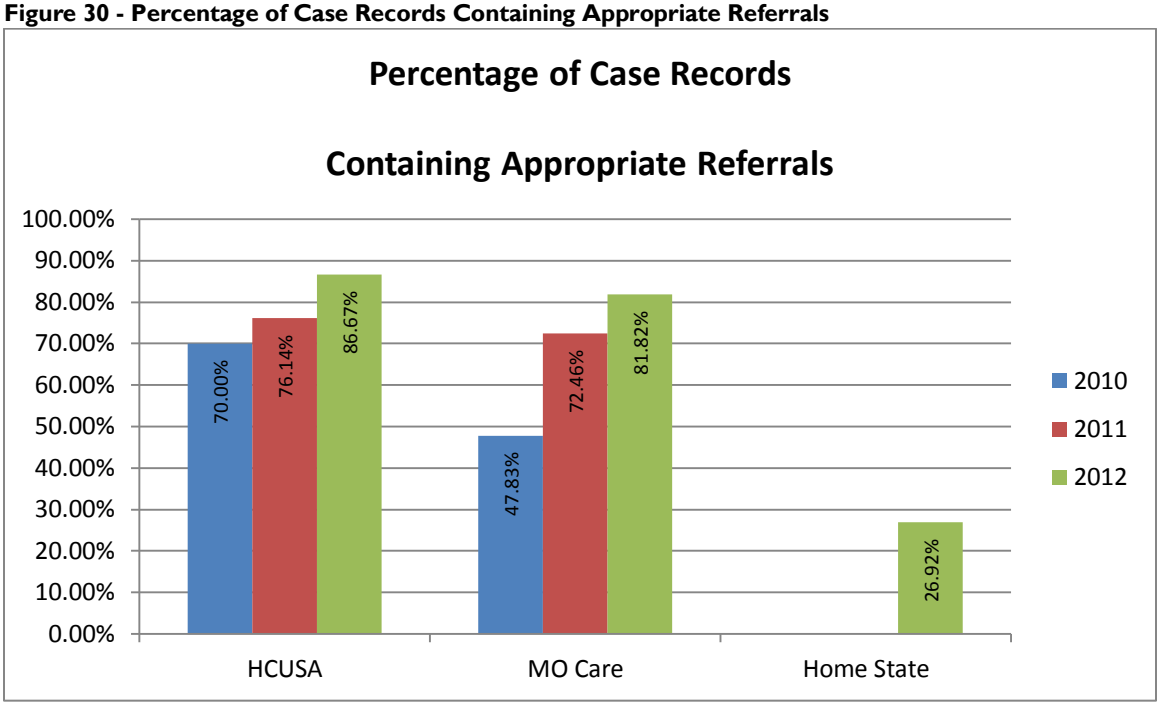
- The care plans are computer system-generated directly from the assessments. During this review more records had care plans with updated information individualized for member during case management involvement.
- Care plans were not included in records, even though case managers stated that all members receiving case management did have care plans in place;
- More member involvement was identifiable in the care plans available. This information was included in progress notes and in updates.
- The case managers at HCUSA and MO Care explained that letters to PCPs and specialists continued to provide an impetus for the physician's office to contact them if they saw an area of concern, such as a medical issue the member did not relate. The case managers also reported that when they contacted the physician's office, staff recognized their name or their involvement with the member.
- At Home State care plans were not included in most cases. It did not appear that care plans were being developed consistently. Case managers admitted that they were not always discussing the need for care planning with members. They also were surprised to learn that they should be sending care plans or sharing care plans with the members and for their PCPs.

REFERRALS

The standards concerning appropriate referrals require that the case manager assess members' needs and make referrals as appropriate.

1. The MCHP must ensure that members have referrals to all required providers, physicians, and specialists.
2. Case managers are required to discuss available services: both in the community and MCHP sponsored; such as transportation.

Figure 30 - Percentage of Case Records Containing Appropriate Referrals



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

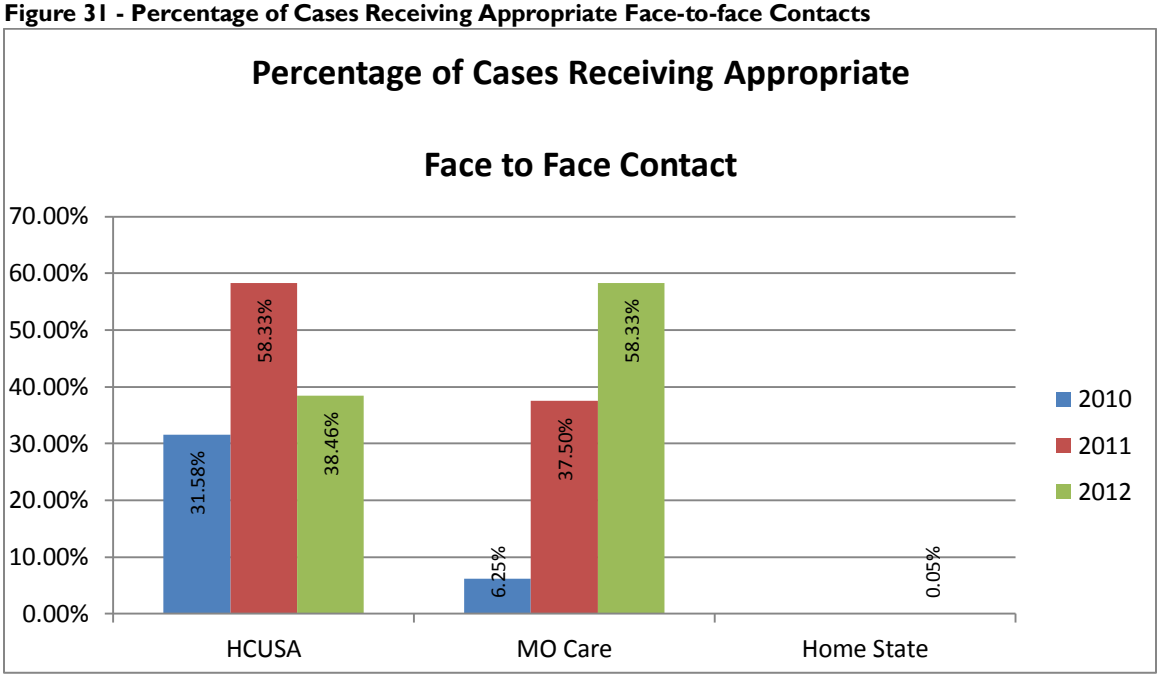
- Both HCUSA and MO Care improved in 2012 in the area of making referrals for members.

- Home State records reflected a lack of knowledge about available resources and case managers were not actively making referrals. During the on-site interviews, case managers acknowledged that they had made improvements in this area, and were now aware of the need to make these referrals. Their knowledge about available resources and support systems for members, both through the MCHP and the community, is an evolving area.

FACE-TO-FACE CONTACTS

The Managed Care contract contains standards that require specific face-to-face contacts for members in lead case management, members who are pregnant, and in other cases as deemed necessary.

Figure 31 - Percentage of Cases Receiving Appropriate Face-to-face Contacts



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

Although the contract language regarding the need to provide face-to-face visits changed slightly, it still contains the expectation that these visits will be made in most cases.

- MO Care showed improvement in this area.
- HCUSA had a significant decrease in the number of cases where face-to-face contacts occurred.
  - In the OB/Perinatal cases reviewed, only one of ten indicated that face-to-face contacts had occurred or had been requested. This is a serious deficiency in attention to service requirements for these cases.
- Home State did not include referrals to third party providers for face-to-face visits in most cases. There were no referrals for face-to-face visits in OB/Perinatal cases, and only one (1) in lead case management. This is an area where the MCHP needs immediate corrective action.

- The MCHP contracts with several agencies to complete in-home or face-to-face contacts. If this is occurring it is not reflected in the case managers' progress notes. In the cases reviewed this information was not available.
- Case managers reported that they know they can refer to outside agencies, and have done so to locate members. They seemed unaware that they can authorize face-to-face contacts for members in OB/Perinatal cases or that this is a requirement in lead cases.

- All three MCHPs report that they do not directly conduct face-to-face contacts with members. They contract for this service. It appears that more referrals and consistent follow-up are required in this area. In addition, information from the contracted agency about member contacts must appear in progress notes.

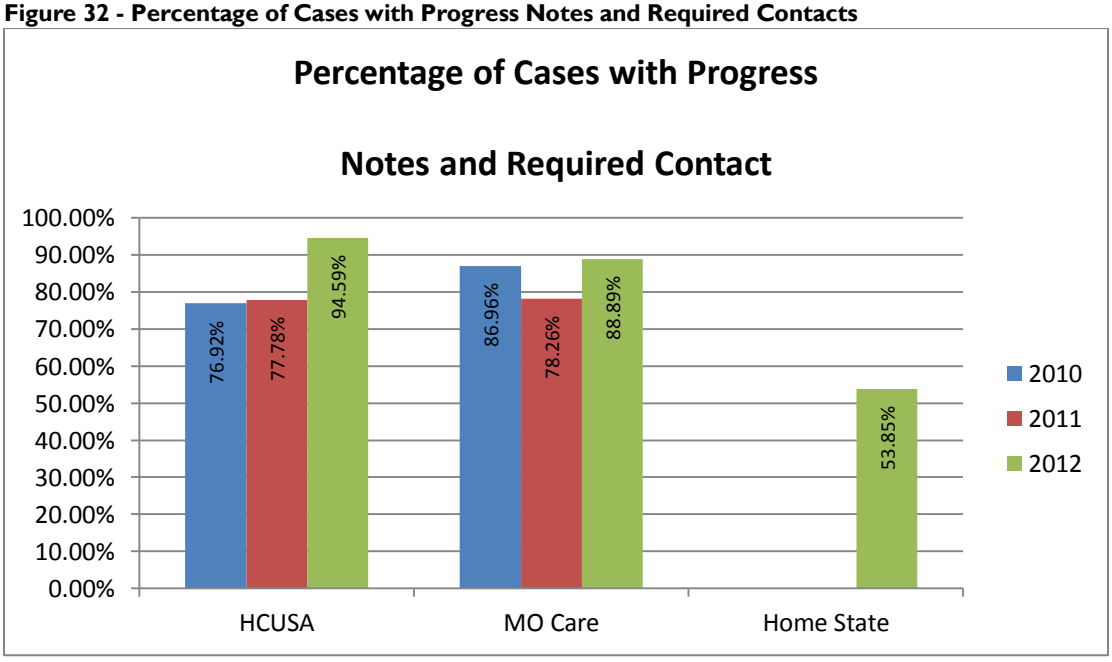
CONTACT WITH MEMBERS

There are two standards used to assess maintenance of proper contact with members.

1. Case records are to contain progress notes updated at each contact or at least every thirty (30) days.

2. Case managers are required to have at least three substantive contacts with a member prior to case closing, and these contacts are to be reflected in the progress notes.

Figure 32 - Percentage of Cases with Progress Notes and Required Contacts



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

- HCUSA and MO Care showed improvement in this area in 2012. These MCHPs improved in providing monthly progress notes, but their rating was negatively affected as the result of fewer cases with the required number of contacts.

- Home State provided monthly progress notes in over 50% of the cases reviewed, but made contacts with members, as required, only 27% of the time.

- Progress notes are completed in the MCHPs' case management systems. The case managers report that the process for recording attempted and actual contacts with members, providers, or others involved with the member is easier than in the past. This was evident in the information provided. In general it was informative and substantive.

- Case managers continue to report difficulty in maintaining engaged relationships with members. They believe this is a barrier to having substantial contact with them.

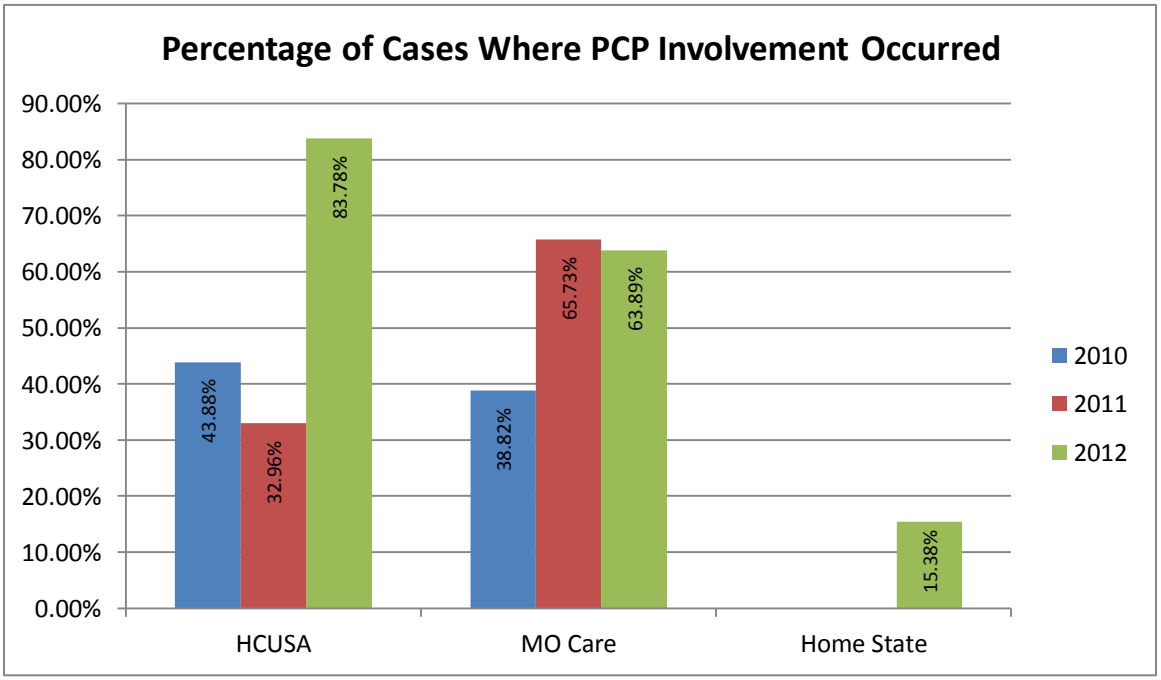
PCP INVOLVEMENT

There are two standards used in measuring PCP involvement.

1. The case manager is to initiate and maintain contact with the member's PCP or primary provider.

2. Case Managers are to inform the PCP at case closing or when the MCHP is no longer providing case management services to the member.

Figure 33 - Percentage of Cases Where PCP Involvement Occurred



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

- When cases close, a letter is sent to the member. Cases are often closed due to loss of contact with the member. Very little follow-up occurs with the PCP or clinic of record.

- HCUSA improved significantly in developing relationships with physicians. The improvement extended to properly informing PCPs about their involvement with members and again at case closing. Case reviews provided evidence that information sharing with the PCPs was an important aspect of their work with members, and they had developed relationships that promoted information sharing with provider offices.

- MO Care decreased slightly in providing information regarding their interactions with PCP offices. Case managers report regular contact and good relationships with providers. However, the information available for review did not validate these comments.

- Home State did not have PCP case record information or case manager support to make contact and develop a relationship with providers. Case managers reported that they could not receive information as the result of privacy issues. They were unaware that as the payer of record or with members' consent they did have access to this information and were expected to create and maintain these lines of communication.

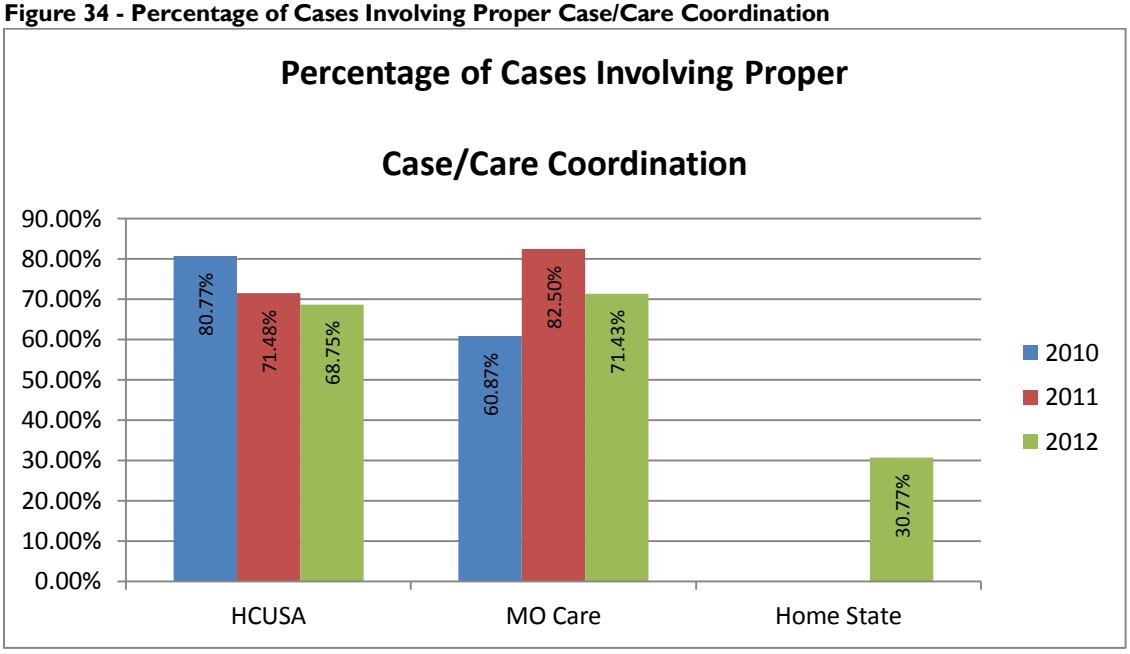
CASE/CARE COORDINATION

There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members.

2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.

Figure 34 - Percentage of Cases Involving Proper Case/Care Coordination



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

- HCUSA and MO Care both decreased in this service area in 2012. HCUSA declined for the second straight year. There is very little attention in progress notes to the need for reporting on case coordination.

- An area of concern is the number of cases reviewed where behavioral health services seemed appropriate. These cases involved a report of depression or a bi-polar condition during the assessment, where no follow-up, offer of referral for services, or a direct referral as the result of a serious situation regarding the member's admitted problems was found.

  - Home State admitted that this was an area of evolving competency. They are working on better recognition of the need for behavioral health services and a better method of making referrals.

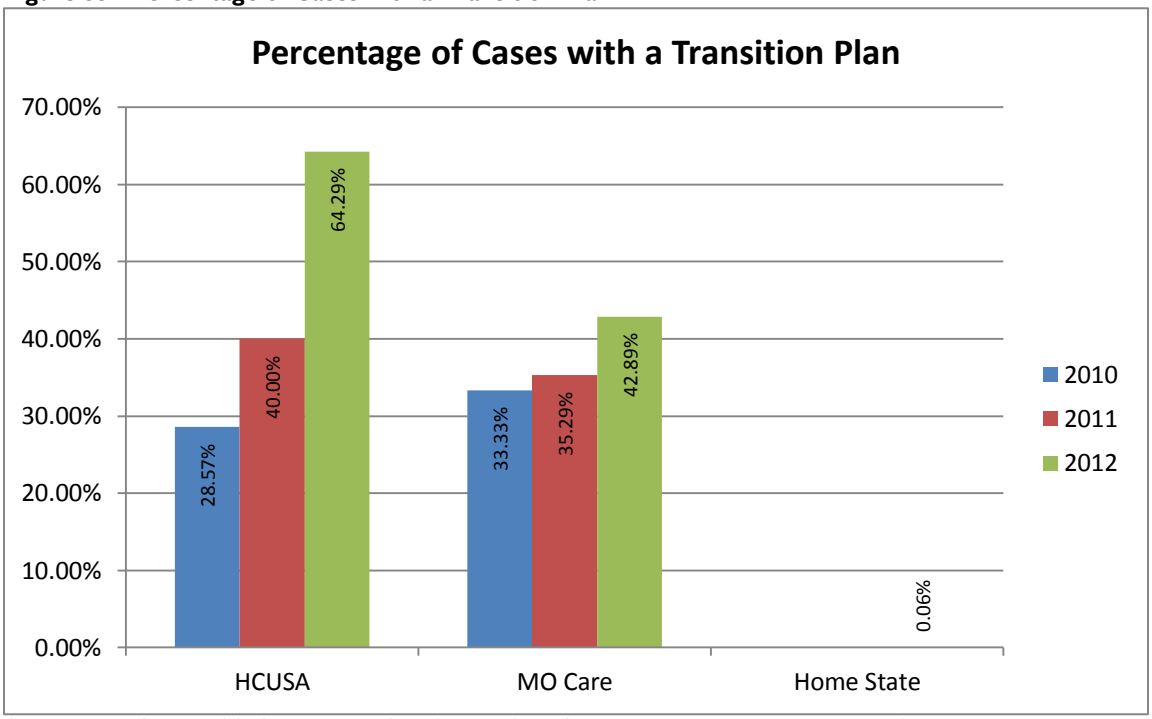
- When the MCHPs successfully recognized and acted upon the members' needs for complex case management, there was active coordination of care.

TRANSITION AT CLOSING

There are three standards included in appropriately terminating case management services.

1. The case manager must be assured that the member has achieved all stated care plan goals.
2. A transition plan must be developed and the member informed.
3. The case manager must ensure that the proper case closing criteria exist based on the type of case management received.

Figure 35 - Percentage of Cases with a Transition Plan



Source: BHC, Inc., 2012 External Quality Review Case Management Record Review

Results of Review

- Completing a transition plan:
  - HCUSA and MO Care showed improvement in completing transition plans.
  - Home State only had a transition plan in one of eighteen (18) cases where a transition plan is required.
  - Some cases remained open so a transition plan was not yet required. There were also cases, which were closed due to lost contact, after the case manager diligently attempted to reengage the member. These cases were coded as "not applicable."

- Some cases with no transition plan did include "Unable to Contact" approved form letters to the member indicating potential case closure. There were no attachments or other information sent to the member, or to involved providers, explaining the members' options or plans for them to maintain their independence.

- Communicate the transition plan to members:
  - Language in approved closing letters stressed the importance of the member maintaining a relationship with the PCP, reminded the member of the availability of the MCHP's nurse advice line, and let the member know they had the ability to contact their case manager if necessary.
  - This should not be construed as an actual transition plan, although it does provide useful information to the member.

- Cases remaining open for follow up services for 60 days after the baby's birth:
  - HCUSA and MO Care both improved in including results of contact with members post-partum.
  - Home State routinely closed these cases right after the birth of the child in the records reviewed. On-site interviews with case managers confirmed this practice. The case managers provide services for up to sixty days if a member requests. The case managers were not aware that they were expected to provide ongoing post-partum services.

5.3 Observations for All MCHPs

Quality of Care

- When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate for extraordinary services to meet members' health care needs.
  - In 2012, reviewers observed improvement in this area for the two MCHPs with previous MO HealthNet experience (HCUSA and MOCare). At these MCHPs, case management services provided referrals and communicated with the physicians or their staff regularly. Case managers assisted members in achieving their goals and stabilizing their health care conditions. They used MCHP sponsored services, linked members to community resources, and ensured the outcome of improved member health.
  - The newest MCHP's (Home State) case managers are learning what is expected of them. They are seeking to familiarize themselves with available services through the

MCHP and to be more involved in ensuring members obtain quality health care services.

- In case records indicating contact with the physician's office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.
  - These cases included many contacts with the physician's nurse or nurse practitioners.
  - Physicians responded directly to inquiries and questions from the case managers.
  - When contacts occur the case notes indicate better and more complete service delivery.

- A number of issues that impact quality were observed that continue to need improvement. These include:
  - Informing or including the PCP in care plan development;
  - Ensuring that all members expected to receive face-to-face contacts have access to this service;
  - Completing and communicating a transition plan with members that provide direction and information; and
  - Informing the PCP and other providers when case management ceases.
- Quality of care is improved when services occurred as seen in the cases opened as the result of Emergency Department referrals (HCUSA and MO Care only).
  - Case managers identified members as High Risk OB cases. Ongoing case management and ancillary services began immediately.
  - Members with multiple issues and complex cases were identified and case management initiated.

- In the area of lead case management, member's quality of care was negatively affected.
  - Home State was not providing the type or depth of services expected.
    - Less than one half of the cases reviewed were actually opened for services or follow-up care. The EQRO is concerned about this MPHC's understanding of the lead case management program.
      - Only one case included home visits or face-to-face contacts as required.
      - Few or no contacts were made with the member or the member's parent/guardian.
      - There was very little evidence of lead case managers contacting public health

departments, Federally Qualified Health Centers (FQHCs), schools, public agencies, or other sources that may have contact with members so they could be located and served.

- Follow-up with and knowledge about the public health agencies involved in lead abatement and intervention was minimal.

ACCESS TO CARE

- Access to care was enhanced in the cases where case managers actively worked with families. In a number of cases reviewers observed creative and relentless efforts to locate members. Some of the MCHPs utilize contractors who "drive by" members reported addresses to learn if the member is actually living there and to obtain forwarding information whenever possible. The case managers contact a variety of sources to track members' whereabouts and make required contacts.

- Access is improved by case managers' efforts to obtain services, community based or by providers, which uniquely met members' needs.
  - Members with complex needs and high risk cases were maintained even while they briefly lost eligibility (HCUSA and MO Care). If these members regained eligibility, continuity of case management services was maintained. In two cases members were followed until another case management or service provider was identified to continue work with the member or the family.

- Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB-GYN and a first visit to the pediatrician for the baby.

- The following problems were observed and had a less desirable effect on members' access to services and health care:
  - Case managers lost contact with members who had newborns at the end of the case management process and no transition plan was developed.
  - Face-to-face contacts did not occur as required, even when a contracted provider was involved. The member did not receive services needed. This negatively impacted health care outcomes.
  - When consistent case/care coordination occurred case managers avoided duplication of services and maximized MCHP resources. However, a lack of these practices negatively

affected members' access to care and was evident in many cases.

- A lack of commitment to members who are difficult to locate or contact was observed in some cases.
  - Cases were received that were only open long enough to make three contacts and then closed. This was not a majority of the cases for HCUSA and MO Care. Home State did not have a consistent practice to locate members. The processes described by Home State staff during the on-site interviews indicated a lack of understanding or of any creative approaches to finding and engaging members.
  - It is imperative that the MCHPs use a consistent approach when attempting to contact members. This will ensure good access to healthcare services.

TIMELINESS OF CARE

When case managers are actively serving a member; fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- When case management occurred in the OB cases reviewed (including the sixty (60) days postpartum,) follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. Parents who received case management services often enrolled their babies with the MCHP and ongoing preventive care could occur.

- Home State case management, as previously noted often ended right after the baby's birth in OB cases.

- Case managers continue to report that they are unable to create a useful transition plan with the member when it appears the case should be closed.
  - Case managers assert that after members' health care needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager. Cases are then closed using the approved standard closing letter with no case specific plan included. This was found less often in two MPHC's (HCUSA and MO Care) than in previous years.
  - Lack of effort to create transitional planning or follow-up with the member creates a

situation where significant healthcare issues resurface due to unachieved goals.

- Information sharing with PCP offices and sending a letter at case closing requires improvement.
  - Case managers' lack of attention to proper case closure negatively impacts members' ability to obtain needed services in a timely manner.
  - Case notes reflect that in many instances instructions are given to the member, with the hope that they will take responsibility for follow-up and timely self-care.
    - The case managers admit that when they have a relationship with the physician's office it is beneficial to their work with the member.
    - Timeliness is greatly improved by ensuring that members, particularly members with special health care needs, obtain all necessary medical services with some oversight.

RECOMMENDATIONS

1. Case managers should copy their own records when cases are requested and review the information submitted. The case notes should include evidence that they understand the information collected through the assessment process or tool. The narrative should explain how this drives the services provided to the member and the development of the care plan.
    - If a case is coded as "high risk", then suddenly recoded as "low risk," the narrative must include an explanation of this change.
2. Case managers have access to a great deal of information in their case management systems. When cases were requested for the 2012 review, a reminder was included asking for all case documentation. It appeared that the records received did contain a great deal of information, although all requirements for the provision of case management services were not reflected in the information provided. Case managers should ensure that all information is included for review.
3. The MCHPs should invest in a model ensuring that members receive the face-to-face contacts required. This may require more direct contact with members or better progress notes when a contracted entity is used.
4. Case Managers must establish a method for including the PCP in care plan development. This may be informing the PCP in writing that case management is involved with the family and a copy of the initial care plan, asking for their input. Follow-up and inclusion of the PCP office in progress reports is an important tool in managing member services.
5. Lead Case Management should include active attempts to make a contact with the member or member's family. A relationship should be established. Opening a case in the system and checking on the member's progress with the local health department does not constitute case management services. However, if members truly cannot be located, follow-up with the local public health department, PCPs, schools, and any other agency having contact with the member must be pursued to ensure that the child's lead exposure and EBLL are resolved.
6. Each MCHP must continue their commitment to finding "hard to locate members." These are often the members who will truly benefit from the receipt of case management services.
7. Complex case management, care coordination, and in some cases disease management, are not consistently defined at each MCHP. This creates confusion in requesting and

reviewing cases. When cases are receiving complex services and coordinated care is occurring this should be reflected in the Progress Notes for the member.

8. Referrals for behavioral health services are crucial. When a member indicates in the assessment that they are experiencing behavioral health issues, such as depression or a bi-polar disorder, follow-up and an offer of referral for services are required. If a member admits to serious behavioral health problems a direct referral should be considered. Recording of these activities should also occur.
9. Concerns remain about the number of cases actually opened for case management. Locating and identifying members, and engaging them in the case management process, is critical to meeting their healthcare needs. Ensuring that MCHP members actually have access to case management services remains a concern.
10. Renewed attention is required in the lead case management program. Many of these cases include multiple children and often include additional issues. Only routinely tracking reported BLL results through public health is a disservice to these members and their families. Even if the MCHP routinely contracts with another agency to provide services in these cases, the services provided and results are to be included in the progress notes. The requirements of this program require these cases be tracked until the child's EBLL is less than 10 or the child disenrolls. In these cases some type of follow up or referral is required. These cases must be properly managed.

6.0 Healthcare USA

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6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HealthCare USA supplied the following documentation for review:

- Readmission Performance Improvement Project
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 25, 2013, during the on-site review, and included the following:

Laura Ferguson – Director of Quality
Karin Ferguson -- Medicaid Region Vice President of Quality
Rudy Brennan – Quality Improvement Coordinator
Carol Stephens-Jay – Senior Health Care Consultant
Dale Pfaff – Quality Improvement Coordinator
Beverly Chase – Quality Assessment & Improvement Coordinator

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Discuss the interventions and the outcomes.
- What were the findings?
- What does HCUSA want to study or learn from their PIPs?
- When does an issue become significant enough to be considered for a PIP?

The PIPs submitted for validation included a substantive amount of information. Additional analysis occurred between the time of the original submission of information and the time of the on-site review. HealthCare USA (HCUSA) was instructed that they could submit additional information including enhanced outcomes at the time of the on-site review. The final evaluation was based on the updated information received.

FINDINGS

CLINICAL PIP – DECREASING HOSPITAL READMISSIONS

Study Topic

The first PIP evaluated was the clinical PIP submission entitled "Readmissions Performance Improvement Project." The study topic presentation explained the research completed by HCUSA justifying the decision for topic selection. The narrative included national, state and MCHP specific data that provided support for the topic choice. The research looked at member needs and the severity of their concerns. This information was supported by a national, regional and local literature review. The problem of unnecessary hospital readmissions was originally identified in 2006 when this PIP was initiated. HCUSA experienced success in decreasing these numbers at that time. In 2012 the MCHP acquired a significant number of new members and the readmission rates increased. In an attempt to meet the challenge of preventing avoidable hospital readmissions the MCHP sought to implement new processes to make the necessary improvements to reach members at risk. The justification for the topic choice supports the goal of improving access and quality of care through ensuring that members obtain the most appropriate health care in the correct setting at the earliest possible time. The result of focusing MCHP resources on reducing hospital readmissions is designed to ensure that members receive the appropriate services and understand the availability of services that best meet their healthcare needs.

Study Question

The original study question presented for this project was:

1) (Updated for 2010) Will early (prior to discharge) identification, screening and appropriate referrals of all hospitalized members by concurrent review nurses result in a reeducation in hospital readmissions as evidenced by a 2% reduction in HCUSA member readmission rate?"
2) (Updated for 2012) Will early (prior to discharge) identification, screening and appropriate referrals of all hospitalized members by concurrent review nurses result in a reduction in hospital readmissions as evidenced by another 5% reduction in the HCUSA member readmission rate?"

The study questions have been updated for each measurement year. The study question is clear and measureable. Each year the updated study question considers the population the MCHP wishes to serve or impact, and the goal for effecting change. The information presented also

included the use of case management as a method for achieving stated goals.

Study Indicators

The study indicators and goals were provided. Each indicator provided numerators and denominators. The narrative explained how current data would be compared to the 2006 baseline year. The only members excluded from obtaining services were hospital admissions resulting from a "23 hour observation" after emergency room treatment, pregnancy related diagnosis, transfers to another inpatient facility, those with zero days between admissions, those leaving against medical advice, or those with a scheduled readmission. Data was provided by region and statewide. What was being measured and the information the indicator will provide was explained. The baseline indicator and the specifications of its development were included in the information provided. The information included adequate documentation to determine if the indicators would measure a change in health status. This also served to explain how they were associated with improved member outcomes. The 2012 update stated that the new goal established for 2013, due to readmissions for both less than 30 and less than 90 days, is a rate that is 5% lower than the previous goal. The new goals were provided and explained.

Study Population

The PIP is focused on HCUSA members who are leaving the hospital with an index hospital discharge and a subsequent hospital admission that does not meet exclusion criteria. Quarterly reports will provide this information. The population to be served is identified through claims data. Any HCUSA member, who does not fall under the exclusion criteria, is eligible for these services.

Study Design and Data Collection Procedures

A study design presented explained the data collection methodology in detail. How claims are received, loaded into HCUSA's claims system, and the controls that exist to ensure valid and reliable data were included. The process ensures accuracy. The main source of original data will come from information stored in the Coventry Data Warehouse. It is then loaded into an Access data base and scrubbed and filtered for exclusions. A standardized query and scrubbing process allows for consistent and reliable data to inform this project. The claims data alone will be used to create the data used to measure the PIP outcomes. How the final data is collected

and reviewed is included in the narrative.

The claims data will be run quarterly. All hospital admissions have a revenue code range and this information is included in the study. How specific information is retrieved is presented in detail. The Coventry system automatically loads submissions in the data warehouse. All data goes through a series of system set-up controls and quality controls to ensure data accuracy and reliability. The project data will go into an Access database to further filter the claims to ensure that the same collection process is used throughout the project. This provides the necessary confidence that accurate data is reported over time.

A complete and detailed prospective data analysis plan was presented. Data analysis will occur quarterly during this project and include: calculating and tracking the overall readmission rate; analysis to identify additional opportunities for improvement; creation of run charts to track improvement; statistical analysis (z-test) conducted yearly to assess change; and a quarterly report to be presented to the project team for assessment and enhancement.

The name of the project leader was provided. All team members and their qualifications or role in completion of the study were specified.

Improvement Strategies

The interventions utilized in this study, their rationale, and the manner in which they were implemented is described. The interventions are listed by date of inception, including a barrier analysis, and the person responsible for completion, and the outcome by project year. Member interventions for 2012 include:

- Development and implementation of disease management programs for most frequent readmissions that started in 2010 was completed and enhanced during 2012, and included an asthma and diabetes program;
- Enhancement of the case management process as an integral part of readmission prevention; and
- Development of an Asthma Home Health program.

These interventions were described in detail. Barrier analysis occurred after each measurement period. Excellent descriptive narrative provided a great deal of information allowing an assessment of what is being done, the desired outcome, the responsible staff for the

intervention, and the date of implementation.

Data Analysis and Interpretation of Results

A thorough analysis occurred taking into consideration all aspects presented in the prospective plan. The analysis included a discussion of environmental factors that did impact the outcomes. The analysis begins in 2007 and goes through 2012. Analysis looked at raw numbers, readmissions by ICD9 codes, and differences in the 1-30 and 31-90 day ranges. A thoughtful analysis is presented.

The analysis looked at the readmissions where case management occurred and reflected on the impact this intervention had on the overall success of the project. Comparisons of the numbers of members who did and did not receive case management occurred. A separate analysis was completed for members who received asthma related case management. The last area of specific analysis also occurred for those members receiving NICU case management.

The analysis concluded that the overall PIP reached its goal of a 5% reduction in the readmission rate from the baseline. Interventions targeting specific populations were effective in lowering readmission rates. In 2012 the MCHP concluded that the interventions implemented during this project year had a significant impact on the readmission rates for both the 30 and 90 day time frames. Continued trends and opportunities for improvement are woven into the discussion. The analysis was thoughtful, included barrier identification, factors influencing outcomes, and an overall evaluation of the success of the project to date. The analysis provided evidence that the interventions positively impacted this issue. The next steps and new interventions in place during 2013 were described.

Assessment of Improvement Process

The report presents information identifying trends and actionable areas to reduce avoidable hospital readmissions. The MCHP plans to continue with new interventions, and with the expansion of those that have proved effective. After continuing extensive assessment of the issues impacting members with asthma, new interventions are planned and have been developed for 2013. This PIP has been active for six years and has met or exceeded its goals during the past two years. The MCHP is in the process of assessing this PIP and replacing it with PIPs that

are focused on specific readmission issues. However, it presents information making it clear that the study process and designing interventions focused on a recognized issue created positive change and enhanced services for members.

Assess Sustained Improvement

HCUSA has implemented a number of interventions throughout the life of this PIP that are now part of regular operations. The decreased readmission rates have met or exceeded the goals set in 2010, including a 5% reduction in 2012. The rate of success has continued to improve over the past two years, and none of the interventions introduced to create these improvements have been eliminated. The interventions that created this success have generally been system wide. HCUSA will now move forward with targeted projects to improve the readmission rates for members with specific difficult health issues such as asthma. All data points to the fact that this improvement will be sustained in regular MCHP operations. With the continued commitment to quality member services, HCUSA will continue to seek new opportunities to reduce avoidable hospital readmissions.

Conclusion

HCUSA intends to continue their successful interventions and to expand their efforts on reducing readmissions to targeted populations. Their work indicates their ability to identify trends and actionable areas to create these reductions. The data indicates that their approach has created an environment of real improvement. The interventions focused on targeting specific populations will continue, and will be reviewed regularly. This approach promises additional sustainable improvement. This PIP provides a high level of confidence that the MCHP will continue to see improvement in the area of reducing avoidable hospital readmissions.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Design

The second PIP evaluated was the HealthCare USA approach to the Statewide PIP "Improving Oral Health." This study is a non-clinical project clearly focused on improving members' health care. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. HCUSA focused their topic discussion on the needs and circumstances of their members. They presented this statewide topic and explained the applicability to HCUSA members. Regional and national information was utilized from a literature review. The information presented included the connection between oral health and general health, and the importance of including good oral health in the prevention of serious physical health issues. HCUSA presented convincing evidence that this is an important area of concern.

Study Question

The original HCUSA specific study question presented is:

- Statewide – "Will providing the proposed interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2012 (data from calendar year 2011) and HEDIS 2013 (data from calendar year 2012)?"

The narrative points out that the 3% increase in the Annual Dental Visit total rates will be measured both as an aggregate of all MCHPs, as well as for each MCHP individually, as part of the statewide PIP initiative.

The updated HCUSA specific questions are:

- "Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2013 HEDIS annual dental visits?"
- Will the addition of targeted provider-assisted, care-centered promotions and dental events improve the regional HEDIS rates for annual dental visits (ADV) by 3%?"

The inclusion of the second question expands HCUSA's focus to engaging providers in the improvement process – for the benefit of members. The study questions are complete and clear. They recognize that HCUSA's success is part of the state total, but also reflects their efforts to create improvement.

Study Indicators

The indicator is presented and explained in the narrative in a clear and concise manner. It is concentrated on the HEDIS rate which is quantifiable and measureable. It draws a relationship between the interventions, their association with the study question, and the likelihood that a positive impact will occur. The numerator and denominator are provided.

Study Population

The study population will consist of all MCHP eligible members from the ages of 2 through 20 in the measurement year. No one is excluded.

Study Design

The study design presented all of the data to be collected and the methodology used. It specifies all data sources. A database report is generated from the subcontractor, DentaQuest's, claims system. This data is then loaded automatically into the Coventry Data Warehouse. It is sent through a series of system set-up controls and quality controls to ensure data accuracy. The narrative explains how the HEDIS Annual Dental Visit rate is calculated for the entire population, how this is loaded into NCQA certified software, with oversight by IT specialists. The narrative describes a systematic method for obtaining and assessing the data received. The HEDIS outcome reports are produced by a Coventry HEDIS team. Additional details, including the CPT codes to be queried, are all provided. Specifications for data analysis are included. How outcomes are reported is provided. All numerators, denominators and rates are analyzed for validity and consistency. The administrative methodology is used to determine the ADV HEDIS rates. This is described in a manner that gives confidence that accurate and consistent data are produced.

HCUSA points out that their baseline data does not follow the HEDIS "allowable gap" criteria. It believes that all members in the MO HealthNet population should be educated on proper dental care. This section states that the progress of each intervention will be tracked and updated on a quarterly basis. Coventry developed a new analysis tool in 2010 that allows HCUSA to review, analyze, and compare monthly HEDIS rates. For example, enhanced member and provider education and community outreach are part of the improvement strategy. If these areas need added attention through the measurement year this becomes evident and

can be implemented in a timely manner. The prospective data analysis plan is understandable, clearly described, and provides confidence that the PIP was developed with these issues in mind. The team members, their responsibilities, and qualifications are described in detail.

Improvement Strategies

The original HCUSA specific interventions implemented included:

- Floating Dentists (dentists who agree to rotate through rural areas);
- Partnering with Community Advocates and Events;
- Collaboration with schools/nurses; and
- After hours/weekend scheduling.

In 2012 the MCHP developed subgroups based on their most effective interventions. These included:

- Collaborating with school administrators and school nurses, which started in 2009;
- Partnering with Community Advocates and Events, which started in 2010;
- Targeted mailings of a new dental postcard to non-compliant members;
- Promoting providers with after-hours/weekend scheduling at Back-to-School fairs, which started in 2011; and
- Collaborating with DentaQuest on the Smiling Stork initiative, started in 2012.

In 2012 the PIP interventions focused on the above categories. They then completed the following activities:

- Continued birthday and missed appointment reminders;
- Development and publication of articles for member and provider education;
- Targeted mailing of a new dental postcards to non-compliant members;
- Distribution of toothpaste and dental floss at school related events by Community Relations staff;
- Sponsoring Doc Bear events that directly allow for dental opportunities for non-compliant members; and
- Promotion of large, urban dental provider to increase access and the development of a Dental Home.

These interventions, their purpose and a thorough barrier analysis were presented. Their reasoning and the history leading to the choices of these interventions were presented clearly and in detail.

Data Analysis and Interpretation of Results

The findings and the analysis of those findings were well presented in the documentation submitted. The analysis did correlate to the prospective data analysis plan. The MCHP presented information including baseline and repeat measurements. It presented a barrier analysis and a discussion of environmental factors that might have an impact on outcomes. The analysis looked at the results regionally and analyzed statewide outcomes. The information provided discussed the validity of the interventions and their relationship to the outcomes.

The data supporting the improvements in the HEDIS rates was understandable. The data was presented for each region and statewide. This included the growth over the base year in percentage points and the percent increase over the base year. In all three regions the aggregate numbers indicate an improvement of 10.83 percentage points and a new increase of 35.41% from the baseline measure. The analysis asserts that the numbers reflect an increased access to providers, and the ability to track and trend information on a monthly basis. Statistical significance testing, using Chi Square analysis, indicating statistically significant change for each project year was included. The analysis presented included the baseline year, and a year to year, as well as an aggregate improvement rate regionally and statewide.

The project manager continues to collect and review ADV rates by region and statewide on a monthly basis. Throughout each measurement year the project manager obtains rates from the QSI database, reports them to the QA&I committee on a quarterly basis, and reports to the HCUSA Dental PIP team semi-annually. This was a complete and thorough analysis.

Assessment of the Improvement Process

HCUSA has continued successful improvement strategies, built on these successes and introduced new methods to create additional success. Their current efforts focused on utilizing Community Relations staff to engage and educate members who had failed to obtain their annual dental visits in the past. They will continue to use collaborative initiatives in this process. The MCHP continues successful improvement strategies and to analyze areas where additional improvement can be achieved. The data demonstrates an increased rate of Annual Dental Visits. The initial and continued improvement points to the fact that the interventions utilized had a direct impact on member behavior.

HCUSA argues that real improvement depends upon continued education and ongoing change in member behavior. They are committed to continue to provide educational efforts for this purpose. They have devised new interventions to enhance the improvement already achieved. They plan to continue their efforts to maintain and escalate their success. The MCHP will continue the analysis process to maintain the correlation between the improvement activities and the ADV HEDIS rates.

Assess Sustained Improvement

HCUSA has made changes and enhanced efforts to create success throughout this PIP. They are committed to future efforts to reach even higher rates of success. The PIP Team developed new strategies and interventions. The MCHP is integrally involved in the statewide PIP efforts and has acted in a leadership role for all MCHPs in ensuring that this PIP remains successful. This investment in the success of this PIP is indicative of their commitment to their own current and sustained improvement in the area of improving oral health for members.

Conclusion

HCUSA intends to sustain the improvement they have made by continued and enhanced efforts to ensure their members receive excellent dental care, beginning with obtaining their annual dental visit. They have efforts in place to collaborate with their subcontractor and to also address this issue with MCHP staff. They provided the criteria they will use to make future assessments of project outcomes. The approach the MCHP is taking indicates that there is a high probability that this performance improvement process will maintain their current level of success and continue to improvement in the future. HCUSA has made successful strategies part of their organizations normal work activities and continues to devise new initiatives to ensure that the outcomes achieved to date continue.

Conclusions

Quality of Care

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the rates of annual dental visits. HCUSA has experienced success with the interventions developed and hopes they will continue to positively impact member behavior. The focus of the clinical PIP was clearly targeted to improve the quality of health care for members by improving member's ability to avoid hospital readmissions whenever possible. The MCHP recognizes the need to help members obtain services that meet their needs and are of the highest quality. Their goal is to help members access the most appropriate level of care at the right time in the right place.

Access to Care

The clinical PIP had a specific focus on access to care by providing case management services to members who had any risk of being readmitted to the hospital. The study sought to ensure that members receive all follow-up and supportive services available to ensure that their post-hospitalization is successful. The non-clinical PIP was based on the theory that improving availability and access to dental care will improve the overall health of the members served. The supporting documentation indicates that these PIPs will improve access to services, and the importance of this factor as major focus on improving member care.

Timeliness of Care

The services and interventions used in the clinical PIP had the specific outcome of improving the timeliness of appropriate services for members who had required a hospital admission. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes indicate positive results. The MCHP believes that continuing their efforts and interventions will have a strong impact on improving timely and appropriate medical care. Their future PIPs in this area will create focus on members with difficult medical issues such as asthma. The MCHP continues this PIP with new and enhanced interventions. Timely access to aftercare was an important focus of this PIP. The non-clinical project considered timeliness of care. Preventive and early dental care is a primary focus. This PIP considered timeliness in looking at the members obtaining dental screenings yearly. The narrative discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and how

the improvement processes worked toward reducing barriers to obtaining these services. By striving to assist members in developing a Dental Home, HCUSA will enhance members' ability to access services on a timely basis.

RECOMMENDATIONS

1. HCUSA focused their efforts on improving the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information clearly supported the goal of improving services and benefits to members in a timely manner. The information provided for the clinical PIP was strongly associated with improving the quality and access to appropriate health care services for members. Narrative information, responding to the requirements of the PIP protocols was well developed and should be continued. HCUSA should continue their approach in developing and reporting on PIPs.
2. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete. The data analysis included in these PIPs was excellent. This method of reporting outcomes should continue.
3. HCUSA continued to focus projects on all MO HealthNet Regions served. Reports should recognize variances in outcomes where they exist, based on regional differences. Projects involving HEDIS measures assist in this as rates are provided for each Region. More analysis of the regional differences would benefit the project evaluation and service delivery to members.
4. HCUSA indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.
5. HCUSA should be diligent about recognizing areas needing improvement that can be developed into clinical PIPs. This has not occurred recently and needs to be incorporated into the organizations quality improvement program.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HCUSA. HCUSA submitted the requested documents on or before the due date of February 21, 2013. The EQRO reviewed documentation between February 21, 2013 and June 16, 2013. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The HCUSA NCQA RoadMap for the HEDIS 2012 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2012
- HCUSA's information systems policies and procedures with regard to calculation of HEDIS 2012 rates
- HCUSA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse
- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures
- HEDIS 2012 Data Submission Tool
- HEDIS 2012 product work plan
- Appendix V: Information Systems Capability Assessment

The following are the data files submitted by HCUSA for review by the EQRO:

- HCUSA_Central_ADV_ File1.txt
- HCUSA_Central_ADV_ File2. txt
- HCUSA_ Central_CIS_File1. txt
- HCUSA_ Central_CIS_File2. txt
- HCUSA_Central_CIS_ File3. txt
- HCUSA_Central_FUH_File1. txt
- HCUSA_Central_FUH_File2. txt
- HCUSA_Eastern_ADV_ File1. txt
- HCUSA_Eastern_ADV_ File2. txt
- HCUSA_ Eastern_CIS_File1. txt
- HCUSA_Eastern_CIS_File2. txt
- HCUSA_ Eastern_CIS_ File3. txt
- HCUSA_ Eastern_FUH_File1. txt
- HCUSA_ Eastern_FUH_File2. txt
- HCUSA_Western_ADV_ File1. txt
- HCUSA_ Western_ADV_ File2. txt
- HCUSA_ Western_CIS_File1. txt
- HCUSA_ Western_CIS_File2. txt
- HCUSA_ Western_CIS_ File3.txt
- HCUSA_ Western_FUH_File1.txt
- HCUSA_ Western_FUH_File2. txt

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Monday, June 24, 2013 with staff responsible for calculating the HEDIS 2012 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2012 performance measures.

FINDINGS

Two of the HEDIS 2012 measures being reviewed (Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status) was calculated using the Hybrid method.

MCHP to MCHP comparisons of the rates of Annual Dental Visit, Childhood Immunizations Status, and Follow-Up After Hospitalization for Mental Illness measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The combined rate for the HEDIS 2012 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 46.29%. This was higher than the statewide rate for all MCHPs (43.98%). This MCHP's rate has trended upward over the past three EQR report years, from 36.37% in 2009 to 46.29% in 2012 (see Table 17 and Figure 36).

The reported Childhood Immunizations Status rate was 61.56% this is comparable to the statewide rate for all MCHPs (60.74%). This is only the second year the Childhood Immunizations Status (combination 3) measure has been audited by the EQRO, and therefore no trend data is available for comparison, however, this MCHP did improve their reported rate from the 2011 rate of 54.63%.

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 49.63%, which is comparable to the statewide rate for all MCHPs (48.76%). Unfortunately, this is the first time since the EQRO has validated this HEDIS measure, that it has decreased from the prior review year. This measure was audited in HEDIS 2009, 2010, and 2011 (43.80%, 48.41%, and 50.25%respectively; see Table 17 and Figure 36.

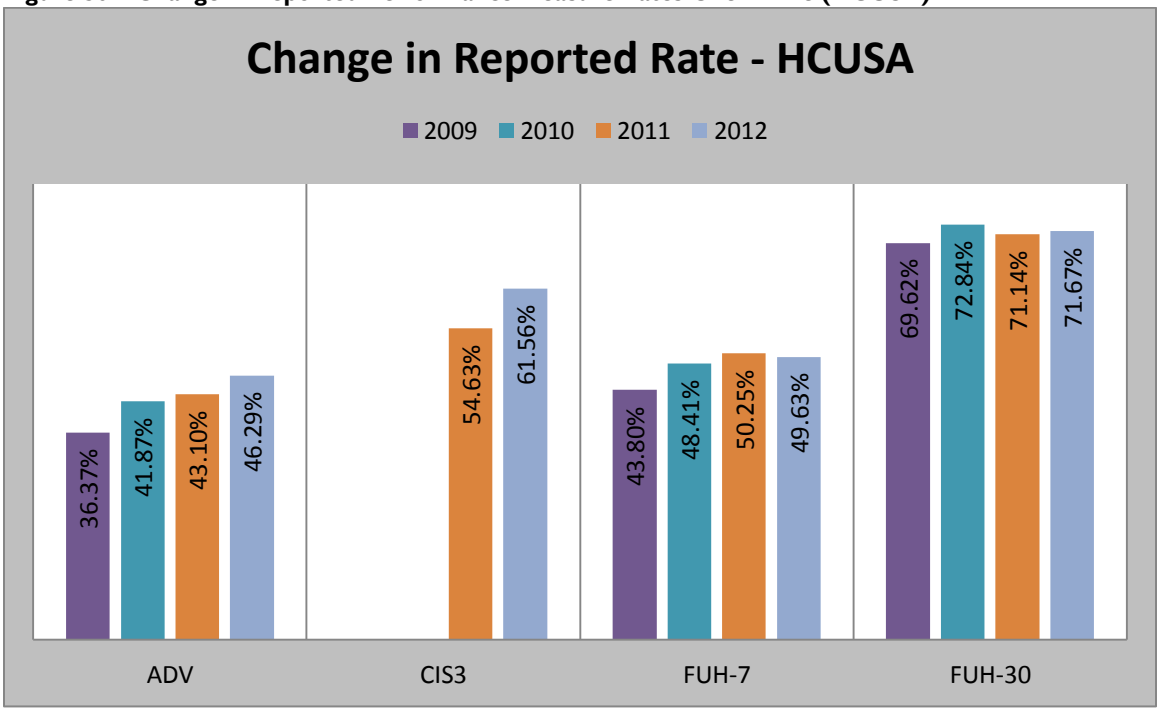
The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the MCHP (71.67%) was **higher** than the statewide rate (65.07%). This rate has continued to trend upward overall, from HEDIS 2009 to 2012 (see Table 17 and Figure 36). This rate is even slightly higher than the rate of 71.14% reported for the prior EQRO review.

Table 17 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	HEDIS 2012 Rate
Annual Dental Visit (ADV)	36.37%	41.87%	43.10%	46.29%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	54.63%	61.56%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	43.80%	48.41%	50.25%	49.63%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	69.62%	72.84%	71.14%	71.67%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year
Source: MCHP's DST's HEDIS 2009-2012

Figure 36 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2009-2012 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

Data Integration and Control

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, HCUSA was found to meet all the criteria for producing complete and accurate data. There were no biases or errors found in the manner in which HCUSA transferred data into the repository used for calculating the HEDIS 2012 measures.

Documentation of Data and Processes

Although HCUSA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were acceptable. HCUSA met all criteria that applied for all three measures.

Processes Used to Produce Denominators

HCUSA met all criteria for the processes employed to produce the denominators of the performance measures validated. This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

There were 110,824 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 7,865 eligible members were reported and validated for the Childhood Immunizations Status measure.

A total of 1,207 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

Two of the three measures were calculated using the Administrative Method (ADV and FUH). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2012 Technical Specifications. Appropriate procedures were followed for the sampling of records for medical record reviews.

HCUSA reported a total of 51,303 administrative hits for the Annual Dental Visit measure; 51,303 hits were validated by the EQRO. This resulted in both a reported rate and validated rate of 46.29%, representing no bias by the MCHP.

For the HEDIS 2012 Childhood Immunizations Status measure, there were a total of 1,129 administrative hits reported and all 1,129 hits found. All 30 of the medical records requested were received, and all 30 were able to be validated by the EQRO. As a result, the medical record review validated 276 of the 276 total hybrid hits reported. Combined with the administrative rates, this yields a reported and validated rate of 59.57%. This indicates no bias (overestimate) of the rate by the MCHP.

The number of administrative hits reported for the 7-day rate for the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure was 599; the EQRO found 598. This resulted in a reported rate of 49.63% and a validated rate of 49.54%, indicating an overestimate of 0.08% bias.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 865 reported hits; the EQRO was able to validate all 865 of them. This yielded a reported rate and a validated rate of 71.67%, again indicating no bias.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. HCUSA was compliant with all specifications for sampling processes.

Submission of Measures to the State

HCUSA submitted the Data Submission Tool (DST) for each of the three measures to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

As is shown in Table 18, the MCHP overestimated the Follow-Up After Hospitalization for Mental Illness 7 day measure. No bias was observed in the Annual Dental Visit, Childhood Immunization Status and Follow-Up After Hospitalization for Mental Illness (30 day) measure.

Table 18 - Estimate of Bias in Reporting of HCUSA HEDIS 2012 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	No bias	N/A
Childhood Immunizations Status (Combination 3)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	0.08%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

Source: BHC, Inc., 2012 External Quality Review Performance Measure Validation

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 19). The rate for the Annual Dental Visit and Childhood Immunization Status measures showed no bias and were therefore deemed Fully Compliant. The Follow-Up After Hospitalization for Mental Illness (7 day) measure wase overestimated, but still fell within the confidence intervals reported by the MCHP. Therefore, these measures were determined to be Substantially Compliant.

Table 19 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Fully Compliant
Childhood Immunizations Status	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

HCUSA's rate for this measure was consistent with or higher than the average for all MCHPs. The MCHP's members are receiving the quality of care for this measure consistent with the care delivered to all other Managed Care members. Both the 7-day and 30-day rates were above National Medicaid Averages and below the National Commercial Averages for this measure. The MCHP's members are receiving a quality of care for this measure **higher** than the average National Medicaid member but below the average National Commercial member across the country. However, these rates continue to hold steady or rise from the rates reported by the

MCHP during the audit of the HEDIS 2009, 2010 and 2011 measurement years, indicating a continuing improvement in the quality of services received by members overall.

Access to Care

The Annual Dental Visit measure was fully compliant with specifications. This measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. HCUSA's reported rate for this measure was **higher** than the average for all MCHPs. HCUSA's members are receiving a higher quality of care for this measure than that delivered to all other Managed Care members.

This rate was **higher** than the rates reported by the MCHP during the prior five years of EQR reports. This shows that HCUSA members are receiving more dental services than in the past. The MCHP's dedication to improving this rate is evident in the increasing averages. This rate was also above the National Medicaid Average for this measure; this is the first time this MCHP's ADV rate has surpassed the National Medicaid Average. This indicates that the average HCUSA member is receiving a **higher** access to dental care than the average National Medicaid member.

Timeliness of Care

The MCHP's calculation of the HEDIS 2012 Childhood Immunizations Status measure was fully compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP's reported rate for this measure was **higher** than the average for all MCHPs. This rate has only been previously audited by the EQRO in 2011, therefore trend analysis is not possible, however, this MCHP's 2012 rate was higher than the rate reported in 2011.

HCUSA's members are receiving care in a more timely manner, for this measure, than that of other Managed Care members. However, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. The MCHP's members are receiving Childhood Immunization care in a manner that is **less** timely than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Work to increase rates for the Childhood Immunizations Status measure; although it was higher than the average for all MCHPs, this rate was below the National Medicaid average.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

HealthCare USA (HCUSA) was subject to a full compliance audit during this on-site review. The content of this 2012 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Assessment of Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of HCUSA's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, HCUSA will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met
Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 20.

Table 20 - Comparison of HCUSA Compliance Ratings for Compliance Review Years (2009, 2010, 2011, 2012)

Measure	2009	2010	2011	2012
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	100%	76.5%	76.5%	88.24%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	90.9%	90.9%	90.90%	100%
Grievance Systems	100%	88.9%	94.4%	100%

Source: BHC, Inc., 2012 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2012 review, HCUSA was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009, 2010, and 2011.

The rating for Enrollee Rights and Protections (100.0%), reflects HCUSA's ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the sixth consecutive year and have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that HCUSA is in compliance with all Managed Care contract regulations and federal requirements.

A strong commitment to member rights continues to be a cornerstone of HCUSA's service philosophy. The emphasis placed on continuous quality improvement by the MCHP was apparent in both the documentation reviewed and throughout staff interviews. As observed in prior reviews, quality services to members, with a particular emphasis on families and children, were observed within the organization. HCUSA views cultural diversity as an essential

component of their interactions with members. The MCHP maintains cultural diversity as a cornerstone of initial and ongoing staff training. HCUSA employs staff that speaks different languages and is able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is shown by the MCHP's approach to their work and to their interactions with members.

The MCHP, in collaboration with MHNet, its BHO, reports making a concerted effort to offer adequate case management services between the two agencies. HCUSA reports that having a MHNet liaison on-site has improved coordination of care issues.

Access Standards

Access and Availability addresses 17 standards. For the 2012 review, HCUSA was rated by the review team to have met 15 standards. This is an overall rating of 88.24% compliance, **higher** than the prior year's review, which found 76.5% compliance.

HCUSA continues to work with both members and providers to ensure proper access to services is available. The MCHP maintains a large provider network throughout all three Managed Care regions. They continue to recruit providers to expand available services, particularly in the Central Missouri area. This network enables members to have an adequate choice of both PCPs and specialty providers. The MCHP does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

The rating regarding Compliance with Access Standards regulations is (88.24%). HCUSA submitted required policy and procedures to the SMA for their approval.

- In reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available.

These findings are detailed more specifically in the Special Project, Section 4 of this report. During the on-site review a commitment to case management was observed, however, the records reviewed did not always contain comprehensive assessments of member needs or evidence of treatment planning.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2012 review, HCUSA was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009, 2010, and 2011. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

During the 2012 Calendar Year, the MCHP continues to follow NCQA standards regarding credentialing. On site visits, to complete credentialing, occur at least annually for PCPs and OB/GYNs. An on-site visit occurs with any office where a complaint has been reported. The MCHP reviews areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers.

HCUSA's provider advisory group is operational in all three Missouri Managed Care regions. The committee is made up of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the MCHP to develop a true partnership with their provider network.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2012 review, HCUSA was rated by the review team to have met all 12 standards. This is an overall rating of 100% compliance, which is **higher** than the 90.9% ratings received in 2009, 2010, and 2011.

HCUSA submitted information to complete the Validation of Performance Measures. They continue to operate a health information system within the guidelines of that protocol. All three Performance Measures were validated and in Compliance with all State and Federal requirements. The details regarding these areas of validation can be reviewed within specific sections of this report.

HCUSA also submitted two Performance Improvement Projects (PIPs) for validation. It was

noted that the MCHP utilized projects that had been started, and perfected these projects in an effort to improve services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2012 review, HCUSA was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **higher** than the rating received in 2011 (94.4%) and 2010 (83.3%), and consistent with the 100% rating received in 2009.

Ratings for compliance with the Grievance Systems regulations indicate that the MCHP completed the requirements regarding policy and practice.

CONCLUSIONS

HCUSA continues to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA, and developing operations that ensure that these procedures are reflected in daily operations. The MCHP maintained improvements to achieve 100% compliance in four sections of the protocol.

The MCHP incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that services to members is their primary focus and that there was a commitment to comply with the requirements of the Managed Care contract and federal regulations.

However, issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.

QUALITY OF CARE

The staff at HCUSA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services. The provider relations staff made

regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the MCHP less complicated. Case Managers relate the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. Treatment planning, assessments and care coordination were areas that the EQRO could not fully validate.

Access to Care

HCUSA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects were explained that bring providers directly to places where members are available. The MCHP has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MO HealthNet Managed Care Regions served.

Internally HCUSA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

Timeliness of Care

HCUSA was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested.
2. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the MCHP.
3. Maintain involvement in community-based services and activities.
4. Continue training efforts with front line staff to ensure that they are versed in MCHP policy and procedures and remain confident in their interactions with and advocacy for members. Be sure that staff who are responsible for written communication with members display an attention to detail so that those letters represent the quality of HCUSA's service delivery.

7.0 Home State Health Plan

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Home State Health Plan supplied the following documentation for review:

- Increasing Notification of Pregnancy Risk Factors
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 26, 2013 during the on-site review. Interviewees included the following:

Wendy Faust – Vice President of Medical Management
Jean Bryan – Manager, Quality Improvement

Interviewees shared information on the validation methods, study design, and findings of PIPs.

The following questions were discussed:

- What instruments were used for data collection?
- How were the accuracy, consistency, and validity assured?
- Why was the clinical project chosen as a PIP for this project year?
- What did the MCHP learn from the findings relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions?

The PIPs were submitted to the EQRO on time, however they required additional information. The MCHP requested technical assistance and had a number of questions regarding the interpretation of the requirements of the protocol. Information was shared regarding the initial

evaluation and the MCHP was provided the opportunity to resubmit the PIPs with additional data, including enhanced outcome information that was not originally available. This final evaluation is based on the updated submissions.

FINDINGS

CLINICAL PIP – INCREASING NOTIFICATION OF PREGNANCY RISK FACTORS

Study Topic

The first PIP evaluated was Increasing Notification of Pregnancy Risk Factors. This is the first year of operation for Home State Health Plan (Home State). This clinical project was implemented in September 2012 when the MCHP recognized they were not identifying pregnant members early in their pregnancy. This interfered with timely interventions when needed. This clinical project focused on increasing the receipt of Notification of Pregnancy forms from providers. The goal of the project was to engage members, particularly those at high risk, into case management. The MCHP also sought to ensure that all pregnant members had access to any needed care and services. The narrative information supported the determination that when early notification of the pregnancy occurs, it creates an environment leading to improved pregnancy outcomes. The topic selection data provided a description of the goals of the project. The use of data pertinent to Home State members and the effectiveness of early pregnancy interventions were described as part of the reasoning for choosing this topic. The importance of early intervention in pregnancy and the resulting benefits of that intervention were supported by the information presented.

The MCHP did not present an extensive literature review, but did provide a convincing argument that an essential issue for improvement was identified. Convincing evidence that members would experience fewer adverse events during pregnancy, give birth to healthier babies, and have positive outcomes during delivery was also presented. The topic selection was clearly focused on identifying and correcting deficiencies in member care and services. It included all pregnant MCHP members.

Study Question

The study question submitted is:

"Will Home State efforts, including education for members and providers on the processes for and importance of NOP (Notification of Pregnancy form) completion, increase the rate of NOP receipt by 25% within 6 months?"

This study question is focused, measureable, specific, and understandable. It identifies the goal and the population to be served.

Study Indicators

The study indicator for this project is the rate of Home State pregnant members with a NOP within eight (8) months prior to delivery. This indicator will be tracked by the MCHP on a monthly basis. The MCHP monitored the effectiveness of their interventions monthly to allow for immediate action if the rate decreases. The data is retrieved through the Enterprise Data Warehouse (EDW). This system houses all claims and authorizations for MCHP members.

The numerator and denominator were provided. The indicators presented were clear, concise, and measurable.

Study Population

The population included in the study is all known pregnant MCHP members. The information provided by the MCHP defines "known" and the system used to identify these members. The MCHP will use a "unique count of Home State members" who had an NOP in their record. The approach used is described in detail.

Sampling

No sampling was used to determine who would be included.

Study Design and Data Collection Procedures

A study design is presented. Data collection and its relevance are defined. The method for data collection and how it will be analyzed is presented. The information includes details regarding data storage and retrieval from the data warehouse. There is a description of how this data is used to generate reports on NOP receipt and risk factors. The sources of data identified in the

study design include the NOP forms and information obtained from PCPs and members. It includes claims submission for prenatal services and with a pregnancy diagnosis. The MCHP then uses these sources, exclusive of the receipt of the NOP form, for outreach and targeted form completion.

The information presented by the MCHP includes the method for data collection and development of metrics for both the numerator and denominator. A procedure was been developed to ensure that the entire population is captured. The MCHP has made an effort to include the capture of all members at several points throughout their pregnancy. The narrative did not give information that specified a systematic method of data collection. An effort was made to include this, but more in-depth information is needed. More information is required to ensure that consistent and accurate data collection occurs over the time periods to be studied. The narrative provided some information on this factor in the study design, but it did not create confidence that the data collection would be consistent and accurate over time. This may be the result of this being a new and initial attempt at reporting on a PIP by this MCHP.

The study design specified some reporting guidelines. The MCHP developed a baseline and is tracking all data sources monthly to obtain the NOP percentages. A plan for statistical significance testing is presented. An explanation of how the MCHP will present any barriers to obtaining the desired results is also included.

The project manager and all team members involved in this study, and their responsibilities were included in the information provided.

Improvement Strategies

The planned interventions for the baseline year (2012) and subsequent years (through 2013) were described. Interventions included:

- Member education efforts
- Outreach to pregnant members
- Telephonic outreach to providers
- Provider education
- CentAccount incentive program

Planned interventions and barriers were discussed. The improvement strategies were provided

in a table that included the changes for 2013 and additional next steps. Barriers were obtained through member and provider feedback. The MCHP attempted to utilize an intense early approach to change behaviors due to the importance of the issue of early pregnancy identification.

Data Analysis and Interpretation of Results

An initial analysis of findings did occur and was presented according to the prospective study design. The results were impressive considering that the MCHP began operations in July 2012, identified an issue to be resolved using the PIP study process by September, and quickly begin implementation of interventions to impact this area of concern. All interventions and analysis were discussed in relation to the outcomes achieved.

The results were presented in figures and tables that were easy to interpret. The information presented was related to the outcomes achieved. There were monthly measurements, including initial and repeat measurements. Although data only covered several months, success throughout 2012 was achieved. Ongoing barriers and threats to success were discussed for the future of this PIP.

Assessment of Improvement Process

This project is too new to assess real or sustained improvement.

Conclusion

This PIP has the potential to reach a significant level of success. Identifying an issue and resolving it using the PIP process has proven to be an effective method for achieving change in member and provider behavior for this MCHP. The analysis of all interventions and outcomes was positive considering the length of the study. Barriers were addressed in a manner that will inform this PIP in future development.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was Home State's individualized approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The rational presented included information related to the statewide PIP study topic decision, and the argument for addressing Home State's population individually. The rationale presented was thorough and based on the need to enhance the approach to MCHP members. The study-topic is well written, understandable, and focused. It has scope and is related to the MCHP. The topic presentation includes in-depth research on the national level and relates this to the Home State members. The narrative information effectively made the argument that this non-clinical approach to a performance improvement project was focused on improving the key aspects of member services.

Study Question

The study question for this project is:

"Will implementing the proposed interventions to Home State members 2 through 20 years of age, increase the rate of annual dental visits per the HEDIS specifications by 3% between HEDIS 2013 statewide average and the Home State HEDIS 2014 results?"

Because Home State will not have a HEDIS 2013 rate for annual dental visits due to implementation of July 2012, the MCHP established HEDIS-like numbers, available through the plan's QSI system. These will be queried monthly to monitor the plan's progress. The HEDIS-like numbers use the procedure codes, age ranges, and enrollment anchor date of December 31 for the HEDIS ADV measure, but not the continuous enrollment criteria.

The study question is focused, includes a specific goal, and informs the reader of the intention of the PIP. The MCHP was aware that there would be no HEDIS results for 2012. It developed a method of measurement using locally established data (HEDIS-like metrics) to determine their success at improving the ADV rate. The results of the 2012 interventions and their relationship to future ADV rates can be established using this interim methodology.

Study Indicators

The MCHP acknowledges the baseline data available using results of the development of the statewide PIP. It is developing locally scripted "HEDIS-like" measures to begin involvement in

this project until they have actual HEDIS data available. The narrative included the argument for providing information related to health status in their study topic narrative. The MCHP did begin work on this project in an effort to improve health outcomes for their members and embraced the PIP process to make these changes.

Study Population

The study population includes all Home State members ages 2-20 ignoring the "allowable gap" criteria in the HEDIS technical specifications for the Annual Dental Visit measure. They are seeking to impact all members in this population.

Sampling

No true sampling was employed in this PIP.

Study Design and Data Collection Procedures

The beginning of a study design is presented. The data to be collected and the methodology to obtain this data are explained, including monthly and quarterly monitoring. The source of the data to be used will come from the MCHP's claims system. The MCHP uses an NCQA certified vendor to validate this data. Current dental CPT codes, formats, and data procedures were presented.

The methodology used to collect data systematically was presented. This information provided confidence that valid and reliable data would be reported. The data collection and NCQA certified software described to validate the data produced was explained. The MCHP presented information on how this data will be analyzed.

A prospective data analysis plan was implied in the presentation. The information provided a table showing outcomes to be reported. However, this was not a complete prospective data analysis plan.

All team members involved, including the project leader, their roles, and qualifications were not provided. The project leader was named, but no other information was included.

Improvement Strategies

Interventions for 2012 included:

- EPSDT coordinator outreach/education;
- Birthday card mailings

The two interventions listed did begin in 2012. Interventions planned for 2013 were presented as well. The presentation does include barriers but no analysis is presented. Additional information on the rationale for choosing these interventions and those planned for 2013 would have been helpful.

Data Analysis and Interpretation of Results

Some information was included, but there is no actual prospective data analysis plan. All information is generalized at this point in this PIP due to the amount of information available.

Assessment of Improvement Process

This information is not yet available.

Conclusion

The foundation of an effective PIP was presented. The MCHP used information available from the Statewide PIP and incorporated this into their planning. Additional time and data will add depth to this project and enable the MCHP to make conclusions about the effectiveness of their interventions. The work done to date does indicate a true commitment to the project goals and the PIP process.

CONCLUSIONS

QUALITY OF CARE

These PIPs focused on providing quality services to members in both the clinical and non-clinical approaches. A quality approach to identifying and educating pregnant members, engaging member's participation in case management and educating providers was evident in the documentation provided in the clinical PIP. Allocation of resources to process improvement was evident in the PIPs presented. The MCHP took on the identification of issues to change and immediately developed PIPs to address problems. This initiative indicates a commitment to quality care for members.

ACCESS TO CARE

Both PIPs submitted by Home State addressed improved access to health care services. The first PIP used a direct approach by engaging pregnant members into health services. In the non-clinical PIP, efforts were made to ensure that members were aware of the necessity of regular dental care and how to obtain this care. The attention to reminding members of available resources enhances member access and directly impacts a positive outcome. The MCHP's efforts were new but they had a clear goal of improving access to care.

TIMELINESS TO CARE

Both projects addressed timely and adequate care. The first PIP, regarding early notification of pregnancy and immediate engagement into services, indicates a strong commitment to timely health care. Another indicator of a focus on timely care is that this issue was identified in the first few months of operation and immediately developed into a PIP to resolve the problem. In the second PIP, regarding improving the rate of annual dental visits, there was attention to assisting the members in recognizing their need to identify a provider and obtain the oral health care available. This MCHP has had a short time to actively work on PIPs and did so quickly and efficiently.

RECOMMENDATIONS

1. Continue to assess PIP activities during the project year to identify issues that may negatively affect outcomes.
2. Continue developing projects to improve member services and healthcare outcomes.
3. Continue requesting technical assistance as needed to utilize the PIP process and enhance member services.
4. Continue to utilize the Conducting Performance Improvement Project protocol in the process of project development and reporting.
5. Continue involvement with the Statewide PIP planning group. Home State has become an integral part of this group. Continued commitment to this group is an important method in an evolving improvement process.

7.2 Validation of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Home State. Home State submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- Home State meeting minutes on information system (IS) policies
- Appendix V: Information Systems Capability Assessment

INTERVIEWS

The EQRO conducted on-site interviews at Home State in St. Louis on Wednesday, June 26, 2013 with staff responsible for monitoring the calculation of HEDIS performance measures, system integrity, and system security. The objectives of the visit were to verify the information contained in the documentation reviewed by the EQRO and to determine the MCHP's readiness for calculation of performance measures in the future.

Interviews were conducted with the follow:

- Wendy Faust, VP, Medical Management
- Jean Bryan, Quality Manager
- Michael Marrah, VP of Operations
- Laura Fraser, Director of HEDIS Operations, Centene
- Paul Hillman, Director of Business Analytics, Centene
- Adam Kaestner, Data Analyst, Medical Management

FINDINGS

Data Processing Procedures and Personnel - Strengths

Infrastructure

The MCHP or their third-party administrator (TPA) employed robust mid-range machines for processing data.

Security

The MCHP had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access.

The MCHP maintained in-house database systems and had good maintenance contracts in place for hardware and software to ensure timely support.

Data Acquisition Capabilities - Strengths

Encounter data

The MCHP or their TPA had formal documentation for processing claims and encounter data. The majority of MCHPs or their TPA had instituted multiple checkpoints for validation of encounter data.

Auditing

The MCHP had a documented process for training claims and billing personnel, which included auditing the performance of new employees to ensure accuracy.

Hardware Systems

Quality and maintenance of computer equipment and software are important in ensuring the integrity and timeliness of encounter data submitted to the state. Desirable features include robust server equipment; hardware redundancy in terms of data storage devices and other key components; premium hardware maintenance contracts; software maintenance contracts for commercial database systems; and a standby server as a backup to the main production server. The MCHP fully met these criteria.

Security of Data Processing

Behavioral Health Concepts, Inc. evaluated the physical security of the MCHP's data as well as

the MCHP's backup systems and methods for protecting the database from corruption.

The MCHP substantially met requirements. The MCHP provided good physical security, a documented security policy, good internal controls, and an effective batching procedure. A secure offsite storage facility is used to store backup tapes; backup tapes are encrypted and transported in compliance with HIPAA.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Home State Health Plan (Home State) was subject to a full compliance audit during this on-site review. The content of this 2012 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of Home State's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Home State will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met
Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 25.

Table 21 - Home State Compliance Ratings for Compliance Review Years (2012)

Measure	2012
Enrollee Rights and Protections	100%
Access and Availability	64.71%
Structure and Operations	100%
Measurement and Improvement	90.0%
Grievance Systems	100%

Source: BHC, Inc., 2012 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2012 review, Home State was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance.

Home State began contracting with MO HealthNet to provide Managed Care services in all three Managed Care regions on July 1, 2012. They have participated in community-based programs throughout all three Managed Care regions and have been involved in school-based health clinics whenever possible. The MCHP participated in back-to-school fairs and other events throughout each region.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to the SMA. All practice observed at the on-site review indicated that the MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2012 review, Home State was rated by the review team to have met 13 standards. This is an overall rating of 76.47%.

Home State submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing case management staff, full evidence of assessments and treatment planning for members was not available. During the on-site review the commitment to good case management practice was observed.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2012 review, Home State was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractor requirements were met.

The MCHP has applied for NCQA accreditation and follows NCQA standards regarding credentialing. All credentialing performed by Home State Health Plan meets NCQA standards and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site.

The MCHP does monitor the subcontractors, detailed histories, problem resolution, and performance improvement are reviewed each year.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2012 review, Home State was rated by the review team to have met 9 standards; one standard was "Partially Met"; and two standards were found to be Not Applicable. This is an overall rating of 90.0% compliance.

The MCHP did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation. The specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section (90. 0%) reflects that all required policy and procedure had been submitted to the SMA for their approval. It appeared that all practice observed at the time of the on-site review met the requirements of the Managed Care contract and the federal regulations.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2012 review, Home State was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance. Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all of the requirements regarding policy and practice.

CONCLUSIONS

Home State was compliant in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at Home State exhibits a commitment to quality and integrity in their work with members. Home State has created tools to educate and inform the community and providers.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Quality was lacking in one Performance Improvement Project.

QUALITY OF CARE

Quality of care is a priority for Home State. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are

evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three Managed Care regions. Home State completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas of the organization.

Access to Care

Home State has made concerted efforts to ensure that members throughout their Managed Care Regions have adequate access to care. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

Timeliness of Care

Home State has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of Home State 's **lower** rates in this year's review.
2. Make every effort to be involved in the community and to cultivate resources to help staff perform their job functions to the fullest potential.
3. Supply training regarding contract requirements to the Case Mangement staff to ensure compliance with all timelines and content standards.
4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.

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8.0 Missouri Care Health Plan

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missouricare

8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Missouri Care supplied the following documentation for review:

- Comprehensive Diabetes Care
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team June 20, 2013, during the on-site review, and included the following:

- Mark Kapp, Manager, Quality Management & Accreditation
- Vicki Mertz, Quality Management HEDIS Consultant
- Erin Dinkel, Quality Management Nurse Consultant
- Karen Einspahr, Quality Management Audit Consultant
- Sarah Minderman, Aetna – on the phone and involved in discussion regarding HEDIS Software

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding new study development, study design, and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who were the staff involved in this project and what were their roles?
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the health plan choose this approach?

- Are these studies ongoing?
- Discuss the effects of these interventions and how they impacted services to members.

The PIPs submitted for validation did contain significant information allowing initial evaluation. The MCHP was instructed that during the site visit that they could submit additional information including updates to the outcomes of the interventions or additional data analysis. Additional information was received for these PIPs.

FINDINGS

CLINICAL PIP – COMPREHENSIVE DIABETES CARE

Study Topic

The first PIP evaluated was "Comprehensive Diabetes Care." This PIP is a clinical project. The MCHP cited a significant amount of research supporting the need to impact the negative effect that diabetes has on the overall health of its members. The MCHP points out that diabetes is the seventh leading cause of death in the United States. The PIP is focused on preventing diabetes, and subsequently improving members' health on a variety of levels, including self-management. It discusses the impact that adult diabetes has on vision impairment, kidney and cardiovascular disease, high cholesterol, and other complicating medical factors. It targets this disease that impacts a broad spectrum of the important aspects of member care and services. The MCHP's stated goal for this adult focused PIP was to promote health behaviors and improve health outcomes through education and on-going interventions.

Study Question

The study question presented was:

"Because of the correlation between managing diabetes and the overall health of the members as mentioned in the Study Topic above, it is imperative that the member obtains the recommended diabetic testing and that the member have control of their glucose level and cholesterol level. By increasing the number of identified diabetic members who at least annually receive HbA1c testing, LDL-C testing, medical attention to nephropathy, and a diabetic eye exam, the health of the member should improve. Therefore, will the plan interventions to members and providers increase the number with HbA1c testing and control, LDL-C testing and control, medical attention to nephropathy and annual eye exams for diabetic retinopathy?" This study question is designed to explain the problem and establish the goal of the project.

The question presented is measureable and specifies project goals, although it is somewhat

complex. The MCHP realizes that complexities exist in addressing this problem. They are taking this into consideration as the PIP moves forward.

Study Indicators

The study indicators that will be used are:

- The annual HEDIS rate for increasing HbA1C and LDL-C testing, eye screening for diabetic retinal disease and medical attention for nephropathy, is the actual measure to be monitored.

The numerator and denominator for this indicator was presented. The HEDIS technical specification definitions were included.

Study Population

The study population includes all members ages 18 – 75 identified as having Type 1 or 2 diabetes. It is MO Care's goal that all members identified in this population have at least one HbA1c test, LDL-C test, medical attention to nephropathy, and a diabetic retinopathy eye exam annually. The MCHP will use their HEDIS methodology, including claims and pharmacy data, to capture all appropriate members.

Sampling

No sampling will be used in this PIP.

Study Design and Data Collection Procedures

The study design presents all data to be collected and the data sources. Details are provided about the MCHP's systems, the software used, and the methodology for system queries. This information is presented for each study indicator. The QNXT system is used to house the encounter and claims information. This is the primary source of information for data collection. The data elements are determined by the HEDIS technical specifications. Each indicator will provide data consisting of the measurement period, the numerator, the denominator, and the rate. The codes and the timeframes used for each indicator are included.

The MCHP explains that they can make some assumptions concerning the collection of valid and reliable data. How the HEDIS data is captured and validated through their vendor is included. The processes are explained in a manner that provides confidence in the study design. The

manner in which data will be collected and utilized to report the success of the project is understandable and thorough. They utilize the HEDIS hybrid methodology, which employs a medical record review to supplement the existing claims data. MO Care staff maintains oversight of all records reviewed. The PIP team obtains the data and updates the PIP. Instruments used and the methodology employed by the team were explained in detail.

A prospective data analysis plan was described. This plan included the stated goal of the study. They wish to show an improvement in members' health outcomes through education and on-going interventions. This will be measured by improving the HEDIS Comprehensive Diabetes Care rates. This indicator will determine the effectiveness of new interventions implemented during the PIP. Within the study design there is information that asserts that MCHP staff will review current data on a monthly basis to monitor the effectiveness of the interventions, and trend rates throughout the year. This will assist in assessing the effectiveness of ongoing interventions. The MCHP is relying on its annual HEDIS rates to provide the validation of the approach to initiating change in member behavior. The information provided discusses goals and the tools they will use to produce findings.

The MCHP personnel involved in this study, including the project leader, their roles and qualifications were included.

Improvement Strategies

The proposed improvement strategies that began in 2012 included:

- ELIZA telephone calls – ELIZA is a patented speech recognition tailored communication via interactive automated phone calls designed specifically for healthcare. Members are engaged in a dialogue based on answers to scripted questions. Information is then provided after receiving requests from the member. The MCHP identified possible barriers to testing that included negative working relationships with the PCPs and/or transportation issues. Solutions are provided during the telephone call, such as transferring the member to Customer Service for assignment of a new PCP or referring the member to the transportation assistance line. The member is informed about other services such as the Disease Management program and a direct transfer to this resource is possible. The calls occur quarterly and are made during day and evening hours.
- Diabetic Mailing – The MCHP formed a work group to evaluate diabetic interventions. A new member mailing was developed covering the following topics:
    - Your PCP Wants to Know About Your Eye Test

- Being Active and Eating Right is Important to Staying Healthy
- Know your Numbers: Diabetes Care Checklist

New letters were mailed with this brochure. The letter communicated the member's last testing date on record, and listed the recommended screenings. This intervention also included updated provider letters and mailings. These were approved during the project year and the MCHP hopes that these efforts will increase communication with diabetic members, educate members on important topics, and improve testing results.

The MCHP has on-going interventions from previous years, but believes that the new approaches may be the most effective to date. MO Care started this PIP in 2010 with interventions specifically designed to initiate better testing. They are now measuring the impact of these practices monthly and looking for significant increases or decreases in indicator rates over time. The MCHP uses a "Plan-Do-Study-Act" cycle to create continuous project improvement. The information presented included the 2012 and previous years' interventions that remain in place, as well as plans for 2013.

Data Analysis and Interpretation of Results

The MCHP explained that HEDIS 2010 (CY 2009) is the baseline for the project. The information presented did comply with the prospective data analysis plan. They presented explanations for what would occur throughout their analysis. All data was clearly presented using tables and graphs, including a narrative explanation of the outcomes. The information included initial and repeat measurements, and statistical significance testing. The results of this testing were presented but not discussed. Factors that influenced the initial and each repeated measurement were not presented.

The narrative that is included in analyzing the success of the PIP and the influence of the planned interventions indicated a decline in the number of members obtaining necessary testing during 2012. The MCHP discussed the need to reassess the current interventions. They did note that all new member education information was not approved in time to fully implement this intervention. The new brochures were not actually mailed until early in 2013. MO Care has planned follow-up activities scheduled for the 2013 calendar year that they believe will contribute to improvement in this measure.

Assessment of Improvement Process

The MCHP recognizes that they must continue to explore new methods to positively impact the results pertinent to this population. They are committed to succeeding in reaching all of their goals, and positively impacting member outcomes. They have not reached a level that can be considered sustained improvement, but are not discouraged from making every effort to reach stated goals.

Conclusion

This PIP is addressing an important concern for member health. Current interventions did not produce the desired results. The MCHP is committed to continue the PIP process and efforts to ensure that adult diabetic members are receiving the services and healthcare that will contribute to their well-being. The PIP is well constructed and appears to have promise to show success in the future. Measureable interventions that are unique to this PIP are important and the MCHP believes that they will determine which initiatives will lead to success for their members in the future. The amount of effort that is evident in the information provided indicates a strong commitment by the MCHP to positively impact this issue.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was MO Care's individualized approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The decision to choose this study topic was supported by information provided in the Managed Care Statewide PIP documentation. The study topic description incorporates the documentation presented in the Statewide PIP into a discussion of its relevance to MO Care members. The narrative includes thorough problem identification pertinent to the MCHP. The MPHC recognized the CMS recommendations for creating improvement in the area of improved access to dental care in their study topic discussion. A literature and research review occurred and the information relevant to the MCHP population is included. This discussion is member focused and points out the importance that good dental care plays in preventing serious medical risks.

The study topic presentation includes the relevant population of members ages 2 – 20 and pregnant women. The stated goal of the PIP is to educate members on the importance of good dental health to overall health. The MCHP intends to provide information to enable members

to obtain necessary care.

Study Question

The study question originally presented when this PIP began in 2010 was:

"Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to Missouri Care members from the ages of 2 through 20 years old and pregnant women result in a 3% increase as measured by the Annual Dental Visit (ADV) HEDIS measure, as well as a decrease in the number of preventable dental-related trips to the emergency room?"

The MCHP added the following explanation to their individualized approach in 2012:

"Through interventions related to this study, Missouri Care plans to show an improvement in members' health. As a result of the study, it is our goal that Missouri Care members ages 2 – 20 and pregnant women will be more likely to schedule a dental visit after being educated about the medical risks of no dental prevention or wellness visits, how appropriately they take care of their teeth, and overall the benefits of dental hygiene. Missouri Care has set a goal to improve members' oral health by showing an increase of the ADV HEDIS rate of 3% over a 3-year period."

This updated study question does identify the original question posed in the Statewide PIP and includes the MCHP's on-going efforts to continue improvement in the area of members' receipt of annual dental visits.

Study Indicators

The primary study indicator (#1) will be improved rates in the ADV HEDIS measure. The MCHP explains that this is actually a reflection on improving members' understanding of the importance of good oral hygiene and obtaining regular dental care. They further state that preventing oral disease will avert unnecessary trips to the emergency room.

Indicator #2 is a rolling 12-Month ADV 'HEDIS-like" rate. This measure is similar to Indicator #1, with the exception that continuous enrollment is waived so that the data trends may be tracked on a monthly basis.

Study Population

These indicators are used to focus on members ages 2 – 20, which is defined by the HEDIS technical specifications. However, this PIP states that it also includes pregnant women, who do

have access to dental care through the Managed Care program. The outcomes will be measured using the HEDIS data. The population will be captured using this methodology. How pregnant women will be included is not addressed.

Sampling

There are no sampling techniques used in this study.

Study Design and Data Collection

The data collection and analysis approach are well planned to capture all required information to evaluate this study. The narrative clearly described how data would be collected and analyzed. The CPT codes and systems requirements are all defined. Claims information is received from the MCHP's subcontractor, DentaQuest. The information provided included sufficient detail, but lacks the complete sense of a true study design. Sections 6.1 and 6.2 are coded as "Met" because the required information is included. The study described the process the MCHP will utilize to extract data monthly and report quarterly.

The specific elements of the HEDIS technical specifications that relate to the Annual Dental Visit measure were included. The database reports described will be generated from DentaQuest's claims processing system. This claims system and the MCHP system are to be queried. Sections 6.3 and 6.4 ask if a systematic method of collecting valid and reliable data representing the entire population is presented, and if the instruments used provide for consistent and accurate data over time. These are both coded as "Partially Met." In previous reviews the MCHP was asked to provide responses in the study design that addressed both of these aspects of the evaluation. What is provided assumes that a great deal of information about the systems and processes is understood. There is nothing in the narrative that actually provides direction in a study design to establish or give confidence that these elements are met.

A prospective data analysis plan was presented. The success of this project is to be demonstrated through quantitative reflection about: 1) An increase in the HEDIS-like rolling 12-month administrative rates during each quarter of the study (starting in the 1st quarter of 2010); and 2) the Annual HEDIS Rate for ADV. The data analysis plan presented does not provide details about how this analysis will occur or how it will relate to the planned interventions.

The data collection staff and members of the PIP team, their roles, and qualifications are provided.

Improvement Strategies

The interventions implemented in 2012 are:

- Dental Day at Local Community Health Centers – Missouri Care and "several" community health centers will work together to open the clinic "a couple days in 2012 to Missouri Care members only for preventive dental services." Members assigned to these centers will be called to encourage them to schedule a dental visit.
- "I Will" Campaign – This is a marketing campaign that seeks to empower members to take charge of their health using the statement "I will brush my teeth. You'll do it, Missouri Care will help." A flyer was developed to be distributed at health fairs, in magazines, newspaper ads, bus wraps and bus interiors.

The MCHP includes actions which they call "continuous" interventions. These have been in place since 2009 and have continued throughout the study. The narrative included all interventions started annually since 2009 and included the projected interventions for 2013. They have built on past initiatives and have attempted to use what they learned from previous approaches to maintain a positive impact on members' behavior in obtaining their annual dental visit.

Data Analysis and Interpretation of Results

The study results are provided and were updated at the time of the on-site review. The data and analysis was completed by region. This analysis was complete and did correspond with the data analysis plan presented. The Central Region used HEDIS 2009 as the baseline data year. The Eastern and Western Regions' baseline year was HEDIS 2011. The success of the project is determined by the demonstrated quantitative data reflecting an increase in the HEDIS ADV, and an increase in the HEDIS-like rolling 12-month administrative rate during each quarter of the study year. A graph of the health plan's annual dental visit rate from 2003 through HEDIS 2013 was presented for each region. This indicated a significant increase, particularly from HEDIS 2009 through HEDIS 2013 for the Central Region. The Central Region HEDIS 2013 rate is 47.36%. The statewide HEDIS aggregate figures increased from 27.41% reported for HEDIS 2009 (CY2008) to the HEDIS 2013 (CY2012) rated of 43.91%. This exceeded the 3% goal set

out in the statewide project. Statistical significance testing was completed and is included in the tables presented by the MCHP. Factors that influenced the outcomes were presented, including outside factors that may have created some improvement on their own. The validity of the data is not in question. There is some question about the direct impact of the interventions. This is explained and considered in the overall analysis.

A separate analysis was completed for the Eastern and Western Regions. In these regions the baseline was HEDIS 2011. The Eastern Region baseline rate was 29.04% and the Western Region baseline rate was 29.18%. There are now two remeasurement periods reported. The results for HEDIS 2013 for the Eastern Region are a rate of 32.52%, indicating a slight decrease from the previous rated of 32.97%. The Eastern Region has experienced growth and the MCHP believes that the interventions introduced did not impact members who were new to the plan. The Western Region's 2013 HEDIS ADV rate was 35.82%, which is a slight increase from the previous year. Although the Eastern Region did not meet its goal of a 3% increase the MCHP believes that with consistent implementation of all interventions this region will respond. The rates in the Western Region have not achieved the success of the Central Region, but they have shown a significant increase.

Not only do the rates exceed the 3% improvement, but significant success has been achieved in each measurement year. The MCHP is now using 2011 for all three regions as a new baseline year for a continued comparison with HEDIS 2012 and 2013. They believe that the current interventions are successful at impacting the members' ability to obtain good oral health care.

The quarterly rolling 12-month "HEDIS-Like" ADV Rate has continued to see an overall increase in compliance with members obtaining their annual dental visit. The MCHP did present a thorough and complete analysis of the outcomes achieved.

Assessment of Improvement Process

The narrative does include an analysis of the data. It also includes a thoughtful interpretation of the effect of the interventions implemented on the outcome and of the barriers and environment issues experienced during this measurement year. A plan for follow-up activities and additional interpretation as new data becomes available is included. The PIP also outlines the interventions to be implemented in 2013. The MCHP continues to measure the impact of the practices developed on a monthly, quarterly, and annual basis. They utilize this data to plan and implement changes, which determines new interventions and approaches to solving problems. The MCHP believes that other normal processes do influence the ADV rate. They admit that the interventions implemented throughout this PIP have greatly contributed to the success achieved to date.

The MCHP did not make a definitive statement about sustained improvement. The narrative did explain and provide evidence that they have witnessed overall improvement in their rate. They believe these improved rates are related to their interventions and maintain a strong commitment to future reviews.

Conclusion

Although the MCHP has achieved success in making the 3% improvements set as the standard in the statewide initiative from the beginning of the PIP, they have not achieved the goal of reaching the NCQA HEDIS 75th percentile. They continue to implement new interventions and to track and trend their initiatives so additional improvement can be achieved. It is apparent that the MCHP uses the PIP process as a method to obtain their improved performance. The process helps them to define issues. They also use it to develop and implement changes in organizational operations that create an atmosphere for growth and continuous quality improvement. The MCHP remains committed to this PIP process and to achieving all of its own stated outcomes.

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by this MCHP. The quality of health care and the issue of the quality of life of MCHP members were both addressed in these PIPs. Enacting measures to ensure that members with diabetes obtain all diagnostic testing on an annual basis, as well as subsequent necessary health care, exhibits the MCHP's commitment to quality healthcare for members. Both PIPs used this process to provide opportunities for primary preventive care enhancing the quality of services received by members. In both projects MO Care stated their planned intention to incorporate these interventions into normal daily operations as the data indicates positive outcomes. Undertaking performance improvement projects that will develop into enhanced service programs for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPs addressed issues that will create improved services and enhanced access to care for the MCHP members. The clinical PIP stresses the importance of testing to ensure that members receive the care and follow-up services they require. The MCHP works with their dental subcontractor and then actively engaged this vendor in enhancing members' access to dental services. The MCHP has implemented mobile dental units in previous years, worked with members to locate and obtain appointments, and exhibits a continued commitment to accessing dental care.

TIMELINESS OF CARE

These performance improvement projects focused on ensuring that members had timely access to care. Implementing strategies to assist members in obtaining important health care interventions in a timely manner is part of each PIP. The projects indicate that the MCHP has this commitment and assists members in obtaining timely treatment. Working with providers to encourage patients to make timely appointments for themselves and their children will enable better health care outcomes.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted continues to improve. Both studies provide evidence that there was thought and consideration put into planning, developing appropriate interventions, and creating a positive environment for the potential outcomes. Ensuring that all aspects of the protocol, Conducting Performance Improvement Projects, are addressed is essential.
2. Continue the process of looking at MCHP statistics and data to analyze the best use of resources in creating performance improvement initiatives.
3. Develop a process for evaluating the conclusions in the projects. Whether interventions are successful or not, draw conclusions based on the data. If an intervention does not achieve the desired result, continue to include information about what happened and why.
4. Utilize a creative approach to developing projects and interventions that will produce positive outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.
5. Continue work on identifying clinical issues to be addressed through the PIP process. Ensure that areas of concern are considered to be developed into a Performance Improvement Processes.

8.2 Validation of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for MO Care. MO Care submitted the requested documents on or before the due date of February 21, 2013. The EQRO reviewed documentation between February 21, 2013 and June 15, 2013. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The NCQA RoadMap submitted by MO Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2012
- MO Care's HEDIS Data Entry Training Manual
- MO Care's Policies pertaining to HEDIS rate calculation and reporting

The following are the data files submitted for review by the EQRO:

- ADV_FILE_1.txt
- ADV_FILE_2.txt
- CIS_FILE_1.txt
- CIS_FILE_2.txt
- CIS_FILE_3.txt
- FUH_FILE_1.txt
- FUH_FILE_2.txt

INTERVIEWS

The EQRO conducted on-site interviews in Columbia, MO on Monday, June 19, 2013 with the MO Care staff that were responsible for the process of calculating the HEDIS 2012 performance measures. The objective of the on-site visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

MO Care calculated the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures using the administrative method. The hybrid method was used to calculate the Childhood Immunizations Status measure.

MCHP to MCHP comparisons of the rates of Childhood Immunizations Status, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported rate for MO Care for the Annual Dental Visit rate was 42.97%; this was comparable to the statewide rate for all MCHPs (43.98%). This rate was a continuation of an upward trend of the rates reported in the 2009, 2010, and 2011 EQR report years (27.41% , 38.21%, and 41.34% respectively); see Table 22 and Figure 37).

The HEDIS 2012 rate for MO Care for the Childhood Immunizations Status measure was 62.69%, 64.14%, which was **significantly higher** than the statewide rate for all MCHPs (60.97%). However, this rate is a decrease from the prior year's rate of 64.14%, as audited by the EQRO, however, there is not enough data to perform a trend analysis.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by MO Care was 40.42%. The rate reported was **significantly lower** than the statewide rate for all MCHPs (48.76%). The rate was **higher** than the rates of 30.34%, 29.20% and 38.42% reported in 2009, 2010 and 2011 respectively.

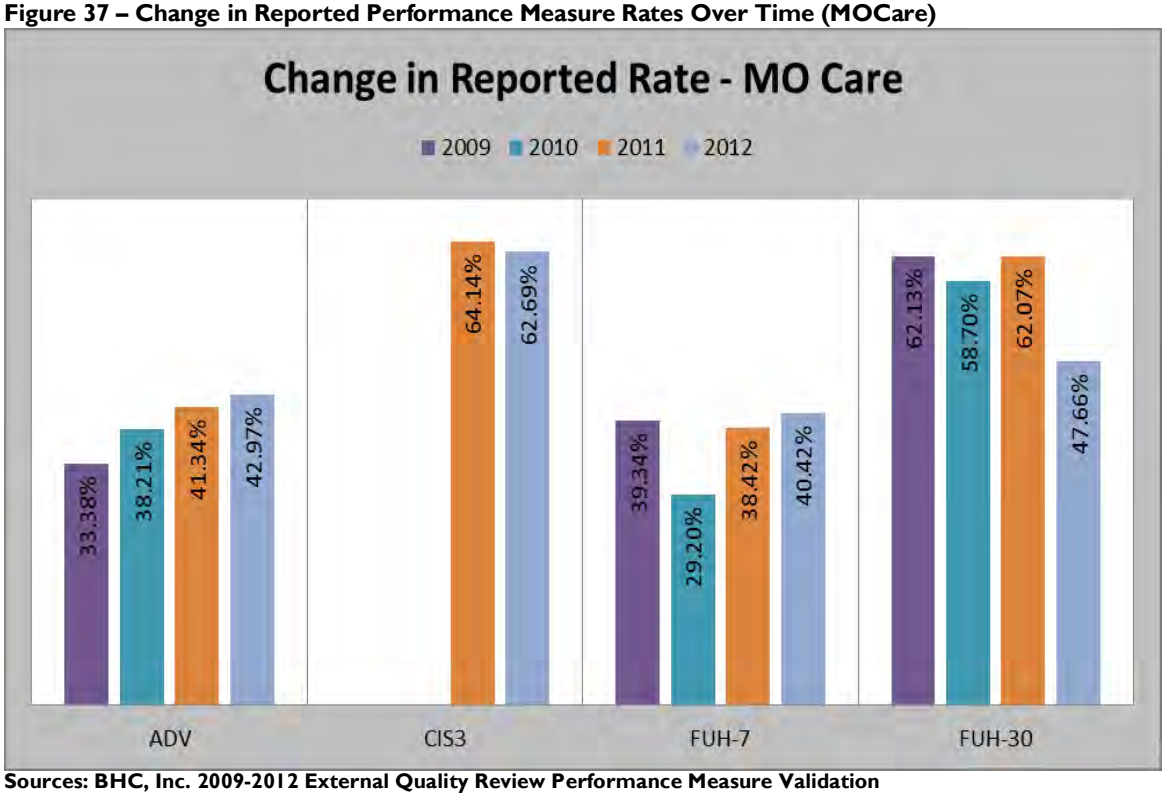
The 30-day reported rate was 47.66%, which was **significantly lower** than the statewide rate for all MCHPs (65.07%). This rate was also significantly lower than the rate reported in 2011 (62.07%), in fact this rate is lower than the rate reported during all preview EQRO audits (see Table 22 and Figure 37).

Table 22 – Reported Performance Measures Rates Across Audit Years (MOCare)

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	HEDIS 2012 Rate
Annual Dental Visit (ADV)	27.41%	38.21%	41.34%	42.97%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	64.14%	66.44%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	39.34%	29.20%	38.42%	40.42%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	62.13%	58.70%	62.07%	47.66%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year
Source: MCHP's Data Submission Tools (DSTs) HEDIS 2009-2012

Figure 37 – Change in Reported Performance Measure Rates Over Time (MOCare)



Sources: BHC, Inc. 2009-2012 External Quality Review Performance Measure Validation

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems (IS) management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. For all three measures, MO Care was found to meet all criteria for producing complete and accurate data. There were no biases or errors found in the manner in which MO Care transferred data into the repository used for calculating the HEDIS 2012 measures.

Documentation of Data and Processes

MO Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2012 performance measures. The EQRO was provided a demonstration of this software, as well as appropriate documentation of the processes and methods used by this software package in the calculation of rates. The EQRO was also provided with an overview of the data flow and integration mechanisms for external databases for these measures. Data and processes used for the calculation of measures were adequate. MO Care met all criteria that applied for all three measures.

Processes Used to Produce Denominators

MO Care met all criteria for the processes employed to produce the denominators of all three performance measures. This involved the selection of members eligible for the services being measured.

For the HEDIS 2012 Annual Dental Visit measure, there were a total of 25,029 eligible members reported and validated by the EQRO.

For the HEDIS 2012 Childhood Immunizations Status measure, there were a total of 1,732 eligible members listed by the MCHP and validated by the EQRO. The samples taken for medical record review were within the specified range and allowable methods for proper sampling.

For the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure, a total of 428 eligible members were identified and validated.

Processes Used to Produce Numerators

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, and dental visits) as specified by the HEDIS 2012 criteria. A medical record review was conducted for the Childhood Immunizations Status measure.

For the HEDIS 2012 Annual Dental Visit measure, the EQRO validated all of the 10,756 reported administrative hits. The MCHP's reported and validated rate was 42.97%, showing no bias.

For the Childhood Immunizations Status measure, MO Care reported 115 administrative hits; the EQRO validation showed 115 hits. For the medical record review validation, the EQRO requested 30 records. A total of 30 records were received for review, and all 30 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate reported and validated by the EQRO based on validated administrative and hybrid hits was 66.44%. This represents no bias by the MCHP for the calculation of this measure.

For the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure 7-day rate, the MCHP reported 173 administrative hits from the eligible population; the EQRO was able to validate all 173 of these hits. The reported and validated rates were therefore 40.42%, with no observed bias.

The 30-day rate showed the reported number of administrative hits as 237; the EQRO validated 237 hits. This represents a reported rate of 47.66% as well as a validated rate of 47.66%, again showing no bias for this measure.

Sampling Procedures for Hybrid Methods

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

Submission of Measures to the State

MO Care submitted the Data Submission Tool (DST) for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

Determination of Validation Findings and Calculation of Bias

The following table shows the estimated bias and the direction of bias found by the EQRO. All three of the measures validated, Annual Dental Visit, Childhood Immunizations Status and Follow-Up After Hospitalization for Mental Illness measures were Fully Compliant.

Table 23 - Estimate of Bias in Reporting of MOCare HEDIS 2012 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	No bias	N/A
Childhood Immunizations Status (Combination 3)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

Source: BHC, Inc., 2012 External Quality Review Performance Measure Validation

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The following table summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 24 - Final Audit Rating for MO Care Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Fully Compliant
Childhood Immunizations Status	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

Conclusions

Three rates were validated for the MCHP. The Childhood Immunizations Status rate was **significantly higher** than the average for all MCHPs, the Follow-Up After Hospitalization rates were was **lower** than the average for all MCHPs, and the Annual Dental rate was consistent with the average for all MCHPs.

Quality of Care

MO Care's calculation of the HEDIS 2012 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

The MCHP's 7-day and 30-day rates for this measure were **lower** than the average for all MCHPs. Therefore, MO Care's members are receiving a **lower** quality of care for this measure than the average MCHP member.

Both the 7-day and 30-day rates were **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** quality of care than the average Medicaid or Commercial member across the country. However, both the 7-day and 30-day rates are **higher** than the rates reported in the HEDIS 2011 audit, indicating the quality of care to members has risen over the past measurement year.

Access to Care

The HEDIS 2012 Annual Dental Measure for MO Care was fully compliant with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving.

The rate reported by the MCHP for this measure was consistent with the average for all MCHPs. Therefore, MO Care's members are receiving a quality of care for this measure that is on level with the average Managed Care member. This rate was **lower** than the National Medicaid rate for this same measure, indicating the MCHP's members are receiving a **lower** access to care than the average Medicaid member across the nation. However, while the rate had continued to fall from 2007-2009, the last three HEDIS audit years (2010, 2011 and 2012)

have shown substantial improvement, indicating an improved access to care for MO Care members.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2012 Childhood Immunizations Status measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received.

The MCHP's reported rate for this measure was **significantly higher** than the average for all MCHPs. Therefore, MO Care's members are receiving a **higher** timeliness of care for this measure than the care delivered to the average Managed Care member.

The rate was **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving Childhood Immunizations in a manner **less** timely than the average Medicaid or Commercial member across the country. However, both the rate is **higher** than the rate reported in the HEDIS 2011 audit, indicating the quality of care to members has risen over the past measurement year.

RECOMMENDATIONS

1. The MCHP's rate for the Annual Dental Visit measure has risen substantially in the last three review periods. The MCHP should continue the programs implemented that have helped to reverse the previously seen downward-trend in this measure.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
4. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
5. The 7-day and 30-day Follow Up After Hospitalization for Mental Illness measure seem to have decreased again for this review year. The EQRO recommends that the MCHP focus on interventions to reverse this trend in rates.

8.3 MCHP Compliance with Managed Care Regulations

METHODS

Missouri Care (MO Care) was subject to a full compliance audit during this on-site review. The content of this 2012 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

Defined organizational structure with corresponding committee minutes

Policies and Procedures

Organizational protocols

Print materials available to members and providers

Report results

Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MO Care's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, MO Care will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met
Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met
Documentation supports some but not all components were present.

N = Not Met
No documentation found to substantiate this component.

N/A = Not Applicable.
Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 25.

Table 25 - Comparison of MO Care Compliance Ratings for Compliance Review Years (2009, 2010, 2011, 2012)

Measure	2009	2010	2011	2012
Enrollee Rights and Protections	100%	100%	100%	100%
Access and Availability	100%	76.5%	82.35%	88.24%
Structure and Operations	100%	100%	100%	100%
Measurement and Improvement	100%	100%	90.90%	90.90%
Grievance Systems	100%	88.9%	100%	100%

Source: BHC, Inc., 2012 External Quality Review Compliance Validation

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2012 review, MO Care was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009, 2010 and 2011.

MO Care continues to participate in community-based programs throughout all three Managed Care regions. They were involved in school-based health clinics whenever possible. The MCHP participated in a back-to-school fair where they not only contacted member families directly, but were able to network with regional primary care physicians (PCPs). Additionally, outreach calls were made to all eligible children. A quarterly newsletter for school nurses was developed and continues to be distributed by the MCHP.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to MO HealthNet. All practice observed at the on-site review indicated that the MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2012 review, MO Care was rated by the review team to have met 15 standards. This is an overall rating of 88.24%, which is **higher** than the 82.35% rating received in 2011 and the 76.5% received in 2010, but is still a decrease from the 2009 rate of 100%.

The MCHP continues to work to develop new and additional resources for their members. The MO Care network includes Kansas City Children's Mercy Hospital, St. Louis Children's Hospital, and the University of Missouri Health Care System. These resources make specialties, such as orthopedic services accessible to members. Pediatric cardiology and neurology are available at the University of Missouri Hospital and Clinics.

MO Care submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff, full evidence of treatment planning for members was not available. During the on-site review the commitment to good case management practice was observed.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2012 review, MO Care was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009, 2010 and 2011. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the seventh year. The MCHP submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractor requirements were met.

During the 2011 Calendar Year, the MCHP became NCQA accredited and continues to follow NCQA standards regarding credentialing. All credentialing performed by MO Care meets NCQA standards and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site.

The MCHP does monitor the subcontractors, detailed histories, problem resolution, and performance improvement are reviewed each year.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2012 review, MO Care was rated by the review team to have met 10 standards; one standard was "Partially Met"; and one standard was found to be Not Applicable. This is an overall rating of 90.90% compliance, which is consistent with the rating received in 2011, but is a **decrease** from the 100% ratings received in 2009 and 2010.

MO Care continues to operate a Quality Management Oversight Committee made up of the Chief Executive Officer, Plan Administrator, Chief Medical Officer, and department managers. The goal of this group was to provide oversight of all operations and MCHP initiatives.

The MCHP did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation, however the quality of one of the PIPs was **lower** than the quality observed during prior reviews. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. The specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section (90.90%) reflects that all required policy and procedure had been submitted to the SMA for their approval. It appeared that all practice observed at the time of the on-site review met the requirements of the Managed Care contract and the federal regulations.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2012 review, MO Care was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **higher** than the rating received in 2010 (88.9%) and consistent with the 100% rating received in 2009 and 2011.

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all of the requirements regarding policy and practice. This is the seventh out of eight years that the MCHP is fully compliant in this section of the review.

CONCLUSIONS

MO Care continues to maintain compliance in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at MO Care exhibits a commitment to quality and integrity in their work with members. The MCHP utilizes unique processes, such as bringing the provision of behavioral health services into the organization, as a method for improving the access, quality and timeliness of member services. They are committed to this integrated approach where case managers utilize the areas of expertise of their team members, yet provide individualized services to members to eliminate confusion. MO Care has created tools to educate and inform the community and providers.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and little involvement of PCPs in the Case Management files.
- Quality was lacking in one Performance Improvement Project.

QUALITY OF CARE

Quality of care is a priority for MO Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three Managed Care regions. MO Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas of the organization.

Access to Care

MO Care has made concerted efforts to ensure that members throughout their Managed Care Regions have adequate access to care. They have recruited additional hospitals and individual providers into their network. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

Timeliness of Care

MO Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing greatly improved case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

Recommendations

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of MO Care's **lower** rates in this year's review.
2. Consider training with Case Management staff regarding treatment planning as this is an area that was lacking in the files reviewed by the EQRO.
3. Show all Performance Improvement Projects the level of commitment that has been granted in the past, successful PIPs can drive the MCHP's future.
4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
5. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.